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THE BRITISH GYNÆCOLOGICAL JOURNAL.

VOL. I.

BOSTON MEDICAL
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BEING THE JOURNAL OF

THE BRITISH GYNÆCOLOGICAL SOCIETY.

VOL. I.

EDITED BY

Fancourt BARNES, M.D.



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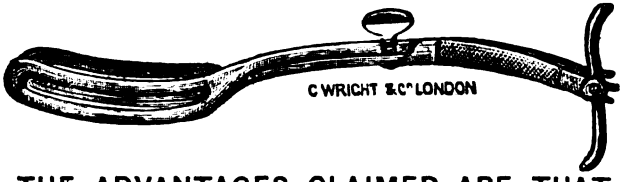
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THE JOURNAL OF THE SOCIETY IS EDITED UNDER THE DIRECTION OF THE FOLLOWING COMMITTEE:

ALFRED MEADOWS, M.D., F.R.C.P., PRES.
JAMES H. AVELING, M.D.
G. GRANVILLE BANTOCK, M.D.
ARTHUR W. EDIS, M.D., F.R.C.P.
HEYWOOD SMITH, M.A., M.D.

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(Dublin); Dr. Lloyd Roberts (Manchester); Mr. Lawson Tait (Birmingham); Dr. Sinclair Coghill (Ventnor); and Mr. Paul Swain (Plymouth).

The CHAIRMAN then said, in opening the proceedings of the meeting, they had met that day, and he was happy to see in goodly numbers, to consider the expediency of establishing a new society for the better knowledge of diseases of women

It was felt by many that gynæcology had latterly made such rapid strides that sufficient opportunities for the diffusion among obstetricians of the daily advances of that science were not given. It would be the business of a new society to provide for this want. There was no intention whatever to oppose or interfere with any other existing society, the Obstetrical Societies especially, which also considered the subject of gynæcology, but it was feared inadequately for the requirements. The object was to further science, not to obstruct it, and they all felt if this intention was fairly carried out, only good to the profession first, and next to humanity generally, must follow. He would not detain them by further remarks, but call upon Dr. Robert Barnes to move the first resolution.

Dr. BARNES, in moving the resolution 'That a Gynæcological Society be now founded, to be called the British Gynæcological Society,' said that he approved of the title selected, and hoped that it would be considered as including Ireland. It was not necessary to justify the foundation of a new society. With the rapid advance of science, the tendency to subdivide medicine to facilitate more accurate study was irresistible. Thus the Pathological, the Clinical, the Obstetrical, the Ophthalmological, and others, had started as offshoots from the Medical and the Medico-Chirurgical Societies. An attempt had been made some years ago to bring back all the new societies into the fold of the Medico-Chirurgical. In the discussion on this scheme he had sided with the late Dr. Murchison, who represented the Pathological, and with Tyler Smith, who saw that this amalgamation would cripple the work of the new societies, by destroying their independence. The time had now come when a Gynæcological Society had become necessary to the freer and more active study of gynæcology, and to challenge a better appreciation and position for those who pursued it. The founders of the Obstetrical Society had a two-fold object: 1, to advance obstetrical knowledge; 2, a political object, namely, to improve the position of obstetrists, and to assert

their right to equality with the physicians and surgeons in the general hospitals. Tyler Smith had claimed the right to conduct his own cases through their entire course, even to operate. He had established the claim to perform ovariotomy at St. Mary's Hospital. To him belonged a leading share in the merit of introducing the method of treating the pedicle by ligature, and dropping it into the peritonæum, a method now universally adopted. Dr. Barnes then touched upon the artificial opprobrium under which those who practised obstetrics and gynæcology had long laboured. The deplorable ignorance of these subjects which prevailed amongst the so-called pure physicians and surgeons disqualified them from judging rightly the practice and conduct of their brethren. What they themselves could not see, they were too ready to suspect was invented. Henry Bennet, who had been mainly instrumental in introducing the speculum in this country, and who opened the way to the study of gynæcology, had been made to suffer. The Fellowship of the College of Physicians had been withheld from him. It was a matter of vital importance to establish firmly the independent right to carry out the surgical treatment of our own cases. This right was now in danger. For its vindication we must depend upon the special hospitals. It is only through the pressure from without, thus brought to bear upon the school-hospitals, that the right could be achieved. Ophthalmic surgery made little or no advance until after the institution of ophthalmic hospitals; and when these had existed for some years, special ophthalmic surgeons were appointed to the general hospitals. These ophthalmic surgeons, as a matter of course, performed their own operations. The obstetric physicians to the general hospitals ought, by parity of reasoning, to exercise the same privilege. This had been conceded in some hospitals. He had emancipated himself at St. George's, because it was known that he could find a field for himself elsewhere. But the privilege, he believed, ceased with him. It was to be regretted that some of the obstetric physicians to general hospitals, including men who enjoyed the privilege

of operating, and men who had not achieved it, were found willing to throw discredit and discouragement upon those who had found an independent field for themselves in the special hospitals. The Gynæcological Society, then, takes up the scientific work comparatively neglected by the Obstetrical Society, and the duty of asserting the just positions and professional rights of the obstetric physicians, including gynæcologists, which the Obstetrical Society by its recent action has abandoned. He was sure its existence would be abundantly justified by honest and useful work.

Dr. HEYWOOD SMITH, in seconding the resolution that had been so ably proposed by Dr. Barnes, said that this meeting was not the result of a hasty or ephemeral effort, but was the outcome of much deliberation for some time past, and it was remarkable that when the conveners of this meeting came to compare notes it was found that many of them had thought of this plan for some years, and had had conversations on the subject.

There was a good *raison d'être* for the formation of such a society, for hitherto gynæcology had lain hidden somewhat under the shade of obstetrics, but now it was high time that it should be represented by a society of its own, as it was daily growing in importance; it had a wider range than obstetrics, its literature was increasing rapidly, and, moreover, general practitioners were waking up to the fact that a more extended knowledge of this branch of the profession was needed by them, in order to keep abreast of the times, than they had acquired during their student days, when gynæcology was in its infancy, and there were but few teachers who could impress their pupils with the importance of the subject.

One special feature they desired to see established was that there should be no curtailment of discussion on specimens and cases brought forward at the meetings, for often a most important subject was thus introduced which might prove of more general use to the Fellows present than a more formal paper.

Again, this Society was to be eminently British, and by that he meant that they hoped to see practitioners joining the Society from all parts of this great empire, for the better furtherance of the science and art of gynæcology, and for the true fellowship of medical men bound by the tie of race and language.

The resolution was then put and carried without a dissentient voice.

Dr. GRANVILLE BANTOCK, in proposing the next resolution, said :—

Mr. Chairman,—The resolution which has been placed in my hands reads as follows :—'That the objects of the British Gynæcological Society be to promote and encourage the science of gynæcology.'

Before proceeding to explain more fully the objects of this Society, allow me to express my concurrence with the disclaimer made by the two preceding speakers, that it is not intended to interfere with any existing societies, but rather to supplement their work. No doubt we shall be told in some quarters that there are already too many societies ; that the Medical Society of London, the Royal Medical and Chirurgical, the Pathological, the Clinical, the Obstetrical, and I know not how many other societies, together with those of a more local and less pretentious character, ought to satisfy all our needs. But this is an old and worn-out argument, and was doubtless used when the younger societies were in contemplation, as it certainly was when the Obstetrical was in embryo. And perhaps we shall be told that we are only seeking to enlarge the range of specialism, a word which has such a dreadful sound to the ears of some men, and has such a serious effect on their minds. Well, Sir, that, to my mind, is one of the chief recommendations of this movement. For, I would ask, what would have been the position of ovariotomy now had it been left in the hands of the surgeons of our general hospitals? What would have been the state of gynæcology generally had it been left to the fostering care of the physicians of our general hospitals? When we reflect on what was the

condition of gynæcology some forty years ago, and contrast it with what it is now, I think we have reason for sincere congratulation. Forty years ago gynæcology may be said to have been an unknown art, and not only so, but the few who attempted to practise it were looked upon with disdain by the physicians and surgeons who prided themselves on the purity of their practice. When my lamented friend the late Dr. Marion Sims was launched upon the world as a full-fledged graduate of medicine, as he tells us, in his own inimitable way, in his 'Story of My Life,' he was profoundly innocent of any knowledge of that art by which he was destined to raise himself to the highest pinnacle of fame. He tells us that if there was anything he hated, it was investigating the organs of the female pelvis. He relates how he was induced by an accident to commence a series of experiments; how, without any help from men or books, he laboured hard at the task he had set himself through four long, weary years of hope alternating with disappointment, until, by a supreme and sustained effort of specialism, he solved a problem which had puzzled generations of surgeons, wiping off a reproach of surgery, which I myself am old enough to have heard called the 'opprobrium of surgery,' and taught us how to cure that distressing condition which, under the name of vesico-vaginal fistula, recalls to the minds of many of us cases of the most harrowing, if not disgusting kind. I contend that it is because men have devoted themselves to one special subject, because, through good and through evil report, they have pursued the *un*-'even tenour of their way,' that ovariotomy is now regarded as the crowning surgical achievement of this century, and that gynæcology has been raised to the dignity of an art, which is now practised with intelligence, and with remarkable success. And as the healing art has been divided into departments, so is it in the world around us. The principle of the division of labour rules everywhere. When I hear a man railing against specialism and specialists, I am moved less with indignation than with pity for his benighted condition; and it is a curious thing that the men

who do this are often themselves either specialists in some other department, or, more frequently, are wholly ignorant of the subject specialised. Depend upon it, the community which, in its working portion, consists of jacks-of-all-trades is not likely to disprove the truth of the adage by producing many masters, nor will it be characterised by the spirit of progress.

We shall perhaps be told that the Obstetrical Society already covers the ground Now, this is what we, the promoters of this Society, contend that it does not. We believe that there is a wide field left untilled by that society which we propose to cultivate. It is true that gynæcological subjects now form a very important part of the work of that society; for while in the first year of its existence, out of 41 communications only 7 were gynæcological, on the other hand, in the year 1882, the gynæcological exceeded the obstetrical in the proportion of 9 to 6, and in 1883 as 9 to 8. This shows the very great stride which gynæcology has made in about a quarter of a century. But it is still more evident in the specimens exhibited, between the numbers of which there is an enormous difference. Now, while the reading of set papers will not be neglected, it is proposed as one of the distinguishing features of this Society, that the exhibition of specimens shall occupy a much more important position than it does a the Obstetrical Society. Encouragement will be given to their full description, and opportunity will be afforded for adequate discussion. Encouragement will also be given to the reporting of individual cases, so that, as we hope, gynæcology may have a fair and open field. We shall thus combine the characteristics of the Pathological, the Clinical, and Obstetrical Societies.

Hospitals for women are gradually being established all over the country (there is scarcely a large centre of population now without one), and only a few days ago I read that at Wolverhampton my friend Mr. Vincent Jackson is moving for an extension of the general hospital in that town in this direction, though he is only a few miles from the great

midland city, and almost in the shadow of that great giant, Mr. Lawson Tait, who I am glad to hear is so thoroughly in sympathy with us. We believe that in the special hospitals already in existence there is a large amount of material waiting to be utilised, that the extension of this system will furnish ever a plethora of material, and that this Society will provide the means of using that material to the best advantage. That the general hospitals have not made the most of their opportunities in the past is only too evident, as Dr. Barnes has already pointed out; and though our hospital surgeons are now bestirring themselves, and showing that they are taking advantage of the lessons many of them have learned from the special hospitals, it is more and more apparent that the special hospitals are a prime necessity.

It cannot be denied that gynæcology does not occupy that position which it deserves, and it will be one of the duties of this Society to enforce its claims, and to agitate—though I don't like the word—for a due recognition of those claims.

I am not deterred from taking part in this movement by the consideration that we may meet with opposition. It required a second period of labour ere its founders were safely delivered of the Obstetrical Society. I believe our symptoms are favourable and warrant a good prognosis, and that there will be no need of a second operation. To overcome this opposition we must work earnestly and steadily, and our motto must be 'A long pull, a strong pull, and a pull altogether.'

Dr. AVELING, in seconding the resolution, said: I believe we cannot better promote gynæcology than by providing means for the oral publication and discussion of matters relating to it. These means are at present far too limited, for, although the Obstetrical Society of London endeavours to supply the want, it does so only to a very slight extent. That society meets ten times in the year, each meeting occupying two hours. If the time taken up by the president's address and ordinary business be deducted, eighteen hours annually are left for the reading of papers and discussion

of matters relating to three great branches of medicine—obstetrics, gynæcology, and pædiatrics. This time, equally divided, leaves for each subject six hours per annum. Now, I ask, is it possible in this short time to consider and discuss the important and pressing questions relating to British and foreign gynæcology which present themselves during the year, and is it not necessary that further means should be provided? We propose to extend the time to six times six hours, and are doubtful whether it will prove sufficient.

The time when midwifery and the diseases of women and children were treated in one volume has passed. An inevitable and irresistible process of segregation has been taking place, and the three different subjects now necessitate the existence of three separate treatises. What has taken place with books seem to be occurring with societies, and it would not surprise me to see, besides this Gynæcological, a Pædiatric Society established to promote knowledge relating to the diseases of children. It has been said of books, as of societies, that their multiplication is a great evil, but, as an enlargement of population demands new houses, so an increase of knowledge necessitates new books and societies for its publication and discussion. I feel confident, therefore, we are met here to inaugurate a most useful and necessary society; and I am equally sure that, working faithfully, fearlessly, and fraternally, we must and shall succeed.

The resolution was then put to the meeting, and carried unanimously.

Dr. GRIGG then proposed that the following be elected officers of the Society for the coming year:—*Hon. President*, R. Barnes, M.D., F.R.C.P.; *President*, Alfred Meadows, M.D., F.R.C.P.; *Vice-Presidents*, Drs. Aveling, Granville Bantock, More Madden (Dublin), Routh, Protheroe Smith, and Mr. Lawson Tait (Birmingham); *Treasurer*, Dr. Arthur W. Edis; *Hon. Secretaries*, Drs. Heywood Smith and Fancourt Barnes; *Council*, Dr. Halliday Croom (Edinburgh), Dr. Sinclair Coghill (Ventnor), Drs. Lloyd Roberts and Walter (Manchester), Dr. Savage (Birmingham), Dr. Sheen (Cardiff), Drs. Wallace

and Burton (Liverpool), Dr. R. Purefoy (Dublin), Mr. Paul Swain (Plymouth), Drs. Culver James, Hope, Grigg, Macwhirter Dunbar, Travers, and Messrs. T. Nunn and H. A. Reeves (London).

Dr. WALTER (Manchester), in seconding the resolution, expressed the great satisfaction it gave him to be present at the founding of a society so calculated to advance the knowledge of gynæcology.

The need for such a society, he knew, had been felt in the provinces for a long time, and as a member of the staff of one of the oldest special hospitals in the kingdom, he congratulated the pioneers of the British Gynæcological Society in having taken a step which would be certainly appreciated by all who were interested in extending the knowledge of gynæcology. He most heartily wished the Society a useful career.

Dr. ALFRED MEADOWS, in moving 'That the meetings of this Society be held twice a month during such months as the Council may determine,' said that though he believed there was at first a little difference of opinion among those who convened this meeting as to whether the Society should meet once or twice a month, yet when he considered the amount of material which he believed would be available for the purposes of this Society, he felt very strongly that they might safely venture upon a fortnightly meeting, and that not only the usefulness but also the popularity of the Society would be greatly enhanced by the adoption of the rule. He felt quite sure there would be no lack of material, for they hoped to draw their support not merely from London but also from the provinces, and indeed from the whole British Empire. A monthly meeting could not give sufficient time for the work which he hoped this Society would carry on, though, as his friend Dr. Aveling assured him, even that would in the course of the year give three times as much opportunity as was afforded by the Obstetrical Society for the discussion of gynæcological subjects. A fortnightly meeting would therefore give six times as much, and this he considered the im-

portance of the subject amply warranted. For this reason he urged the adoption of the resolution which he had moved.

The resolution was seconded by Dr. J. MANSELL-MOULLIN and carried.

Dr. HOLLAND, in proposing the next resolution, said: Mr. President and Gentlemen,—I have the honour to propose that the subscription to the British Gynæcological Society shall be one guinea per annum, and that there shall be no entrance fee. I need make no further comment than to observe that I believe the conditions reasonable, and likely to add to a rapid increase of our numbers.

Dr. BEDFORD FENWICK thought there should be an entrance fee. The resolution, however, having been seconded, was put and carried unanimously.

Dr. LIGERTWOOD then proposed and Dr. BEDFORD FENWICK seconded the following resolution: 'That all duly-qualified medical men be eligible for election as Fellows of the Society.' This was carried.

The proceedings were then brought to a close by a vote of thanks to the chairman.

THE INAUGURAL MEETING OF THE BRITISH GYNÆCOLOGICAL SOCIETY.

MARCH 11th, 1885.

ALFRED MEADOWS, M.D., F.R.C.P., PRESIDENT, IN THE CHAIR.

THE inaugural meeting of the Society was held at 11 Chandos Street, W., on March 11, at 8.30 P.M. Present: 72 Fellows; 10 visitors.

Professor WALLACE (Liverpool), in response to the President's call to show the first pathological specimen to the Society, took the opportunity of thanking the Fellows, on behalf of himself and the provincial Fellows, for this mark of courtesy. Dr. Wallace then described the specimen as part of the body and fundus of the uterus, involved in a mass of multiple fibroid tumours, submucous, intramural, sessile, subperitoneal, and pedunculated subperitoneal. With these were both ovaries and oviducts. It was removed the previous day by abdominal section, and the stump of the uterus was treated extra-peritoneally by the écraseur clamp. With the exception of a little pain, the patient did not suffer from any effects of such an operation, her pulse twenty-four hours afterwards being normal, and temperature 99° and normal. The patient was aged 39, a widow. Never pregnant, and had been the subject of the growths for five years. Twice she had hæmorrhage, and after each attack menstruation ceased for three months. She was under observation for two years, and as she did not suffer any inconvenience, Dr. Wallace advised her to leave them alone. However, during the last two months hypogastric pain, chiefly in the left side, attacked her, and gradually became unbearable, rendering her unfit for any

exertion. This pain was distinctly localised by repeated examination to the pedunculated subperitoneal portion of the tumour, and the cause was locking of this mass beneath the pelvic brim. Altering its position gave temporary relief in the horizontal position. On standing it became unbearable. Her physiognomical expression was that of anxiety, worry, and pain. Two sources of danger to the life of the pedunculated fibroid were now imminent, namely pressure and twisting of the pedicle. One or other of these might produce necrosis, septic peritonitis, and the death not only of the tumour but also of the patient. Dr. Wallace then asserted the importance of a knowledge of principles to guide us as to when extirpation was demanded and when it was unjustifiable. Persistent pain associated with a pedunculated fibroid he laid down as one principle which indicated clearly the necessity of surgical interference. The pathological appearances of the tumour demonstrate this clearly. On excision it was seen that two oval patches, measuring together four inches by two, over its fundus differed from the other peritoneal covering in colour, was œdematous and swollen, having the appearance of wash-leather. Numerous emboli were seen shining through, as well as through the adjacent healthy though somewhat injected peritonæum. On incising the patches and laying open the structure of the tumour, the blood-vessels were seen obstructed with black embolic clots more or less in degree. No form of myxomatous degeneration was to be seen.

Dr. ROUTH asked Dr. Wallace whether in his case it would not have been better to wait before proceeding to extirpation. This tumour was attached (if he had rightly understood him) to the fundus and body of the uterus. The pain in it was indicative either of inflammation in the tumour —for fibrous tumours were generally painless unless inflamed —or cancer, pain being often the diagnostic sign between a fibrous tumour and cancer. If it was inflammation, in time it would have led to its breaking down and absorption *per vias naturales*. If cancer it was best left alone. Was it not therefore better in this case, unless he could certainly have

diagnosed its character, not to have operated at all, and so avoided the great risk of extirpation?

Dr. EDIS entirely concurred in the opinion expressed by Dr. Wallace as to the expediency of removing tumours of this nature when the symptoms were sufficiently urgent to justify an operation. Although a patient might not be dying from hæmorrhage, still the amount of pain and inconvenience experienced might preclude her from fulfilling her duties, whatever they might be, whether laborious or otherwise. It was no argument against operative interference to assert that fibroid tumours seldom killed patients.

Dr. BANTOCK thought the new Society was to be congratulated on having such an important specimen to commence with as that brought before them by Dr. Wallace. He cordially agreed with Dr. Wallace in thinking the operation a most justifiable one. But he went further than Dr. Wallace, and hoped the time was not far distant when it would be considered the best practice to subject these cases to operation at a much earlier period than was now the rule. They had often been told that fibroid tumours very rarely endangered life; that when they did so it was by hæmorrhage; and that unless a patient's life was threatened by excessive loss, hysterotomy was unjustifiable. According to his experience, excessive hæmorrhage was much less frequent than pain, in which Dr. Wallace found the justification of his interference in the case under discussion. Moreover when pain was a prominent symptom he invariably found that some portion of the mass was undergoing or had advanced in that change which Dr. Wallace called necrosis, but what he (Dr. Bantock) was in the habit of calling *cystiform* degeneration. This was a condition which was almost invariably accompanied with some degree of the inflammatory process and consequent adhesions. Time was when they were advised to delay ovariotomy until the patient's life was in danger, estimated by her inability to walk more than a mile. They now knew that many a life was sacrificed to this rule of practice. Believing that a patient with an ovarian tumour was always in danger, they

now acted on the opposite rule, and operated as soon as they could, and they all knew the result. He hoped, therefore, that in time the same rule would, with judgment and with a remembrance of the essential character of the disease, be applied to fibroid tumours. He had to regret several fatal results due to too long delay, *i.e.* until other important organs had become affected, especially the kidneys. He was far from implying that every case of fibroid tumour should be operated on. Experience was directing them to a proper selection.

Mr. LAWSON TAIT said that he felt quite sure that if Dr. Routh had examined the specimen submitted by Dr. Wallace he would have seen that a part of the fundus had been removed, simply because it formed the pedicle of the tumour. There could be no doubt that promiscuous removal of such tumours was to be deprecated, for no operation could be justified with a mortality of 25 per cent., and the mortality of hysterectomy practically remained at that yet. So that any one who removed such tumours without good cause would speedily find an end alike to his proceedings and his practice. Dr. Wallace's case, however, not only showed complete justification for the operation, but it did more than that. It was an illustration of the propriety of interfering early in such a case rather than waiting until the patient was half dead from the progress of the tumour or from acute peritonitis caused by its death.

Dr. WALLACE replied, and thanked the Fellows for the kindly manner in which they had received his observations. The subject was an important one, and large work had to be done before hysterotomy for fibroids was put upon a proper basis. No doubt all gynæcologists were conscientious enough —at least from their own point of view—in extirpating these growths; yet some declined interference—and Dr. Wallace was one of them—unless forced to do so. These tumours underwent involution far more frequently than was accepted by the profession. The operation was attended by a high mortality. To extirpate, therefore, a tumour simply because

it was a tumour, which gave the patient little or no trouble, and which in all probability would finally disappear, implied a taking of responsibility on the part of the operator which Dr. Wallace always declined.*

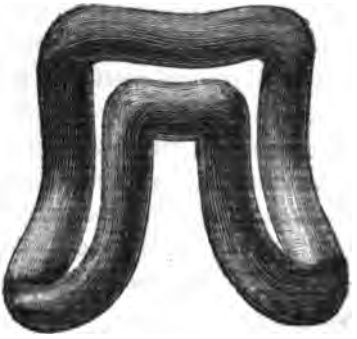
Dr. AVELING exhibited two Fallopian tubes and ovaries which he had removed from a patient, in the Chelsea Hospital for Women, suffering from double pyo-salpinx. Both tubes contained a large quantity of pus, amounting to 15 oz.

Dr. EDIS thought the majority of these cases arose in consequence of gonorrhœa, and if the history was carefully gone into there would generally be found evidence of this.

Dr. BANTOCK exhibited a vaginal pessary which he had removed on the 24th of February from a patient aged 67, who was the subject of an abdominal tumour and incontinence of urine. The internal parts presented the usual appearances. On introducing the finger into the vagina he encountered the pessary, crusted with phosphates, and after its removal he found that the incontinence of urine was due to a large hole in the vesico-vaginal septum formed by the pessary. The history of the case was to the effect that the patient was the subject of what she called 'falling of the womb'—presumably cystocele—that the pessary had been introduced about fourteen months ago, that after eight months she began to lose her urine, and that for the last two months she had lost all control. While he had a profound conviction as to the value of the pessary when properly used, he was equally conscious that it was very frequently abused. He had seen many instances of improper use, but had fortunately never seen such a miserable case as this. He pointed out that the natural form of the vagina might be represented by a thin section of a pear slightly bent into the shape of an elongated letter S, one side representing the vesico-vaginal septum and the other the recto-vaginal. These two septa, in their normal relations, lie in close apposition to one another. As the object of the pessary was to maintain in their natural relation parts that have

* Five days after the date of this operation the patient was doing well. She may be looked upon as convalescent.

been restored from a displaced condition, it is obvious that the pessary should disturb these relations as little as possible. This is a fundamental principle. In the case of the instrument in question, it was easy to see that it violated this principle in the most egregious manner. This was not to be wondered at, seeing that it was the contrivance of a non-professional man. The instrument went by the name of Blackbee, and although he had long been acquainted with it he had never used it, for he had always contended that it was both faulty in construction and dangerous in action. Dr. Bantock hoped the time was not far distant when gynæcology would be taught in such a way that medical men would not be launched upon the world wholly ignorant, not only of the mode of action of the pessary, but of the manner of applying it. He had seen it applied in a doubly reversed position. He had lately read that 'the treatment of displacements was approaching a more rational estimation,' but it was not reassuring to find that these were the words of one who took the negative side of the question, who believed neither in displacements nor in pessaries. He thought some of our London teachers might be better employed in showing their pupils how to use the pessary, that they might not abuse it, than in simply decrying the instrument. Only in this way would poor suffering woman be saved from the baneful results of unskilful and ignorant treatment.



Dr. AVELING said that a great deal of mischief resulted from the careless employment of pessaries, and that there were some practitioners who gained a reputation for skill simply by removing the instruments introduced by bunglers. All spring pessaries were bad. He had lately removed one which had eaten into the vaginal wall, and a band of tissue

had grown over the embedded portion. The pessary could not be removed until this band was divided.

Dr. SINCLAIR COGHILL (Ventnor) said he had paid much attention to the mechanical treatment of uterine displacements, and had a large experience in the employment of pessaries. He had been continually struck with the want of knowledge among general practitioners—using that term in its widest, not its technical sense—as to the nature of the cases requiring artificial supports and the mistakes made in using the latter, of which he instanced an amusing example. He was inclined to attribute this ignorance generally to want of acquaintance with the exact anatomical relations of the parts involved, which were indeed for the most part erroneously described in the text-books, and to the neglect with which the subject of diseases of women was treated in the curriculum of the medical schools, disabilities which he thought the Society they were met that night to inaugurate would do much to remove.

Dr. DOLAN (Halifax) said that the British Gynæcological Society was doing good service in directing attention to the use and abuse of pessaries. He could testify to the frequency with which these appliances had to be removed. The history of such cases was simple. Pessaries were introduced and left *in situ*, and became in time incrusted, as was seen in the specimen shown by Dr. Bantock, and then they had to be taken away. The teachers of obstetric medicine in the metropolis should in their lectures instruct those who would be the future practitioners in the true use of the pessary.

Dr. HEYWOOD SMITH wished to know, with regard to what Dr. Bantock had said as to the upper part of the vagina being the larger and its normal closed condition, whether it would be possible to lay down any guiding rule for the construction of pessaries that would accord with this condition and shape. Dr. H. Smith considered that as misplacements resulted in or were occasioned by abnormal conditions of the vagina, pessaries must be constructed to obviate such misplacements irrespective of the normal state.

Dr. BARNES said he had a patient in St. George's Hospital in whom a large opening had been made into the bladder by a cotton-reel which she had introduced to cure leucorrhœa. With the view to prevent misunderstandings, and to ensure on the part of the patient full knowledge of what was done and of what she ought to do after a pessary was applied, he thought it should be a rule to give her a memorandum in the form of a prescription, stating that a pessary had been applied, and directions when it should be removed or examined.

Dr. BURTON (Liverpool) said he was of opinion that medical attendants were often blamed unjustly for pessaries being kept in too long. He thought that although in some cases medical men might not give all the necessary directions, it was more frequently the case that proper instructions were given, but that patients themselves neglected them. It was rather owing to carelessness or stupidity on the part of patients that evil followed the wearing of pessaries. He himself always gave full instructions, and he would give medical men, as a rule, the credit of being as careful as himself.

Dr. MEADOWS then delivered the following address :—

Gentlemen, my first duty, privilege, and pleasure in taking this chair is to thank the Fellows of the British Gynæcological Society for the great honour they have conferred upon me in electing me as their first President. There are always circumstances connected with the foundation of a new scientific society which, in my judgment, make the selection of its first officers, and notably that of the president and secretaries, a matter of much deeper importance, both to the welfare of the society and to the special branch of knowledge which that society is intended to cultivate, than attaches to the selection of their successors; for, in the older societies, those whose reputation is made, whose usefulness is established, whose position is therefore won, and their existence maintained as much perhaps by tradition and past history as by present work and exertion, their corporate life goes on in an almost automatic fashion. To them, therefore,

the selection of their officers is a matter of much less moment than it is to a society which has to carve its way in the scientific world, to demonstrate its utility, and even to prove the necessity for its existence. The relative responsibility of the chief officers in the two cases hardly admits of comparison, and it is, in my estimation, a singular privilege and honour, equalled only by its responsibility, to be the first chosen representative of such a society as this, one which has been called into existence for the express purpose of cultivating more thoroughly than can be done without it a special branch of human knowledge, a particular department of medical practice, equal at least in importance to either of the other three departments of medicine, surgery, and obstetrics.

In making these remarks, I am sure I do not overestimate the importance of my office in this Society when I contemplate the work we have to do, the aims we have set before us, and the determination which, I believe, animates us all to make for this Society an honourable and useful position among the other scientific societies. Enthusiasm in our work, devotion to our subject, unselfishness in our purpose, a true scientific spirit, a deep conviction of the utility and even the necessity for such a society—all these combined must be productive of a successful issue. I would also venture to hope, and to feel every confidence in hoping, that, avoiding all petty rivalries, eschewing all unworthy jealousies, and conducting the affairs of the Society with true dignity of purpose, and animated by kindly consideration for the opinions of those who differ from us, we may win for this Society, if I may so say, a social status, both in the profession and out of it, which shall command respect for its opinion, and admiration of its work. I cannot doubt that the proud position which I occupy to-night as your first President is due quite as much, perhaps more, to your too kind appreciation of my efforts to advance the study and practice of our department of medicine, as to any special fitness of mine to preside over a society which, I confidently

believe, is destined very speedily to take a foremost rank among the scientific societies of this country. I hope I need not assure you that nothing shall be wanting on my part, so far as my time, opportunities, and abilities extend, to earn the confidence you have reposed in me, to win for our Society the respect and esteem of the profession at large, and, above all, to do that for which, in the terms of our first law, 'the British Gynæcological Society is founded,' namely, 'to promote the science and art of gynæcology in the British Empire'—a noble purpose truly, when we consider all that that object implies. I must add that I feel the more confident of success in my efforts to promote the objects of this Society when I remember that I have the invaluable assistance of two Secretaries who are indefatigable in their work, and whose zeal is well tempered with wisdom and discretion. Already the Society owes much of its success to their exertions. Dr. Heywood Smith was one of the first to found the Society; indeed, it was he who first spoke to me on the subject, while Dr. Fancourt Barnes has to my knowledge worked day and night since its first institution, and he may well be proud of the result.

I suppose that one of the first duties incumbent on a new scientific society is to show the *raison d'être* of its existence. Why are we here to-night? What grounds have we for desiring to establish this Society? What need is there for its foundation? In a word, why do we as a society exist? My answer is a very simple and straightforward one. We hold that the science and art, the study and practice of gynæcology, are yearly growing in importance and interest, and that there is no society at present existing outside our own which fully satisfies our wants, or comes up to our just expectations and requirements. Some of us have felt the need of such a society as this for many years past, till at last the conviction in our minds has developed into action, and the result thus far has exceeded our most sanguine expectations, for already our roll of original founders numbers no less than 266, thus demonstrating in the surest and most

practical manner that this Society fills a want which the profession at large, and especially our brethren in general practice, have long been conscious of. No doubt it may be urged by some who are ignorant on the subject that the sister society of obstetrics already occupies the ground which this is intended to cover; but it is no detraction from the usefulness of that society to say that, if it seeks to represent exclusively not only all that relates to obstetrics, but also all the diseases of women and children, it simply aims at the impossible, and those of its members who have at heart the true interests of gynæcology should welcome the foundation of this Society, and do their best to promote its objects. The mass of material on the subject of gynæcology which exists even in this great city alone, to say nothing of the rest of Great Britain and Ireland, is more than can be grappled with and utilised by any society which includes also in its aims the advancement of the great subject of obstetrics. In proof of this statement the following facts are surely sufficient. There are in the course of the year ten meetings of that society of two hours each, giving a total of just twenty hours. Of these at least two hours are consumed in the presidential address, the reading of the minutes, and other formal matters of business, leaving a residue of only eighteen hours in the whole year which are to be devoted to the three subjects of gynæcology, obstetrics, and the diseases of children. Assuming that each subject has its fair share of attention, we get just six hours per annum devoted to the study and practice of gynæcology. No wonder, then, that for many years past we gynæcologists have felt the need of another society, and we may well congratulate ourselves that now we shall have no less than eighteen meetings a year of one and a half hour each, giving us in all twenty-seven hours for the discussion of subjects exclusively gynæcological. I do not wish for one moment to disparage the great work which the Obstetrical Society has done and is doing, but the quarter of a century which has elapsed since that society was founded has seen marvellous changes and wonderful develop-

ment in the science and art of gynæcology, and I maintain it is impossible now for such a society as the Obstetrical adequately to represent the increasing importance of this subject, or to devote to its study that time, care, and attention which we gynæcologists think it deserves. We have, in fact, outgrown that society, and having arrived at years of discretion, we have decided at length to cut adrift from our pupilage, and to endeavour to stand alone. At the same time we recognise no necessary antagonism to the sister science and society of obstetrics; on the contrary, we desire to be co-workers in one great field of medical practice, believing, as we do, that there is ample room for both, but convinced also that the growing importance of our branch of medical science imperatively demands that it should have a society of its own.

As one of the original Fellows of the Obstetrical Society, I can well remember its foundation, and I know that those who started it had chiefly in view the study and improvement of obstetrics; this, indeed, is abundantly evident in the opening address of the first president, Dr. Rigby, who, both in that and the subsequent address which he delivered in his second year of office, never once alluded to the subject of gynæcology, but devoted his attention entirely to that of midwifery; indeed, his mind on the subject is clearly shown by the statement which he made, namely, that 'the great object, and that which will form the great strength and importance of this (the Obstetrical) society, is the collection of valuable facts on questions of obstetrics;' and Dr. Tyler Smith, the second president, expressed the same opinion when he said, 'the chief business of an obstetrical society should be to diminish the mortality of childbirth.' No one who reads those addresses would imagine for a moment that the Obstetrical Society of that day had anything to do with the diseases of women. I am quite aware that the society endeavours to, and does successfully, cultivate the study of gynæcology, but, with the best intentions in the world, it cannot be true to the spirit of its founders, and, with the

time at its disposal, devote sufficient attention to the many important topics connected with this department of practice.

And here I would mention another very noteworthy fact as collateral evidence of the necessity for such a society as this, and of the wisdom and foresight of those who are its founders. Quite recently, the managers of the International Medical Congress, which is to be held at Washington in 1887, have decided to sever the connection between gynæcology and obstetrics, and have made of each a separate section; thus publicly expressing their opinion, in which I need hardly say we entirely concur, that each subject is of sufficient importance to be treated separately, and to have a section to itself. I cannot help thinking that this example is not unlikely to be followed by other medical associations.

So far, then, as the subject-matter is concerned, its importance and its merits fully justify the step we have taken; and though it is sometimes said that we ought never to prophesy unless we know, I will on this occasion venture to prophesy, and with absolute confidence in its fulfilment, that if the affairs of this Society are wisely, judiciously, and impartially administered, if no favouritism is shown to individuals in the selection of men to fill important offices, except the favouritism which is rightly due to honest work well done, to faithful services rendered to the Society, and, above all, to undoubted ability in those selected for their respective offices—if these are the motives which are to guide the managers of this association, and if the rank and file of the Society will lend their helping hand and contribute their quota of work to the common store, then there can be no question that our future will be a brilliantly prosperous and successful one, and the good work which the Society is founded to car y on will redound to the credit of each individual member, and be of incalculable benefit to the whole human family. This, gentlemen, and nothing less than this, will justify our existence, and this I am satisfied we all intend our Society to be and to do. And when we look at the vast store of materials which this country possesses,

and especially this great city, with its many special hospitals, and its special departments in the general hospitals for the treatment of the diseases peculiar to women; when we consider the ability, zeal, and earnestness, not to say enthusiasm, of the workers in this department of practice, and the honest efforts and intentions of those who founded this Society, I cannot have the slightest doubt that in a very few years this association will take the very foremost rank among the gynæcological societies of the world. Only ignorance of the subject, or motives of a not very creditable order, can question the propriety of its foundation; and to those who urge that there is no room and no necessity for *two* societies having similar aims in view, I can only reply that *we* at all events have no doubts and no misgivings as to our position in the matter, nor have we any doubt as to the need for an obstetrical society also; but while we admit this, we claim for the British Gynæcological Society a scientific position certainly not inferior to the sister society of obstetrics.

Admitting, then, the need for such a society as this, and fully appreciating the work which it is called upon to do, let me for a few moments glance at some of its special features as they are portrayed in the laws which you have passed to-night. First, let me point out that the Society is incorporated under the Companies Act of 1862, as amended by the Act of 1867, section 23. There are obvious advantages in this incorporation which it is unnecessary for me to allude to.

Next, I would remark that by our laws 'all duly qualified medical practitioners shall be eligible for election as Fellows of the Society.' Thus it will be seen that the constitution of the Society is upon the broadest possible basis, and that as the profession has accepted women into its ranks, so this Society by its laws does not exclude them. At the same time, of course, it must be remembered that any applicants for admission into the fellowship of the Society must run the gauntlet of the ballot-box, whatever their sex may be; for the ballot is always supposed to be, and is, the leveller of all distinctions, not excluding sex.

Another feature, and one which I feel sure will prove very attractive and useful to our Fellows, especially to those living some distance from London, and who are thereby prevented attending societies, is the intended quarterly publication of a 'Journal of Gynæcology,' containing not only an account of the transactions of the Society, but also a report of the progress of gynæcology at home and abroad. Such a journal, appearing at short intervals—for we hope in time that it may be published bi-monthly—will be of great use and much practical interest not only to those of our own Fellows who are unable to attend our meetings, but also, I venture to think, to the great mass of our brethren in general practice throughout the British Empire. It will also be of much greater value to those who read original papers, or exhibit specimens of unusual interest at our meetings, that their contributions should be published earlier than would be the case if they appeared in a yearly volume of transactions. It has always seemed to me a great drawback to original workers who read papers at our societies, that their contributions, if published in full in the society's transactions, may have to wait many months before publication, and can only appear in abstract in the medical journals, or if for the sake of early publication they appear in full in the latter, then they are but briefly mentioned in the transactions of the society, which thus becomes shorn of much of its value and interest. All this our quarterly journal will obviate, and I feel confident, therefore, it will not only be a commercial success so far as the funds of the Society are concerned, but will be far more interesting and attractive to our own Fellows.

There is yet one other novelty provided by our laws, which I believe will prove very attractive, and may become of much value and importance. I allude to that law which allows that 'the Council shall have power to arrange for meetings of the Society in the large towns of Great Britain and Ireland on such occasions as they may think fit.' This provision will not, of course, affect the ordinary fortnightly meetings, but is intended rather to supplement them by meetings held in any

part of the United Kingdom, wherever it may appear that a successful gathering is likely to result. I can quite believe that these occasional meetings will greatly enhance the scientific popularity of our Society in this country. They will not be interfered with by picnics or excursions to interesting objects in the neighbourhood, which, though often most enjoyable and sometimes highly interesting and instructive, yet can hardly be said to enhance the particular scientific interest of the meeting, nor I fear in our case would they advance the special claims of gynæcology. Speaking for myself, and I doubt not I might add other officers and Fellows of the Society, I should look forward with much interest and pleasure to such occasional meetings in some of the large towns of the kingdom, where gynæcology is both taught and practised in the most advanced way. Take, for instance, the town of Birmingham, where our friends Dr. Savage and Mr. Lawson Tait would, I am sure, be able to give us infinite pleasure and instruction by their pen, their scalpel, and a visit to their wards; other Fellows, I have no doubt, could arrange meetings of equal scientific interest and value.

Lastly, it is intended that special opportunity shall be afforded for a full and free discussion of the various exhibits brought forward at our meetings. I am sure this is a matter of the first importance. It has often struck me as very regrettable that specimens in connection with which most important questions of diagnosis, pathology, and treatment are associated, and upon which most valuable discussions might be held, are quietly disposed of with only a few cursory observations, and probably no critical discussion at all, merely in order that 'the paper of the evening,' as it is called, may be brought forward; not infrequently, too, these papers, while they show much learning, much book-lore, and much of that sort of experience which is derived rather from the book-shelf than the bedside, are sometimes singularly wanting in practical value, and do not help us at all in actual clinical experience.

These are the sort of papers which I hope the Gynæcolo-

gical Society will not be anxious to obtain, and for which I trust we shall never be willing that the discussion on valuable specimens and cases shall be curtailed. I earnestly hope that the Fellows of this Society will strive continually, by the sound practical character of their work here, to advance our art as well as to elevate and perfect our science. We ought to endeavour, as far as we can, those of us at least who have special knowledge derived from special and exceptional experience and opportunities, to make this Society do a great and real educational work. Even the most experienced among us may learn much at our meetings, for we are all, even the oldest, students in a very true sense. How much more, then, may those of our Fellows who are busily engaged in general practice profit by attendance here, listening to the tale of carefully recorded cases, and the calm, sober judgment and criticism of men whose lives are spent in the special study and experience of this department of practice. On the other hand, I would earnestly invite those gentlemen who are engaged in general practice to favour us with some of their experiences, to tell us of their difficulties and doubts, and if they ever make mistakes or meet with failures, as I am quite sure *we* often do, to give us the benefit of such experience, in return for anything they may learn from us. In short if this Society fulfils its proper mission it may, and in my opinion it ought to, become a great educational institution; and remember, gentlemen, that there is quite as much, indeed perhaps more, to be learnt from the record of failures and mistakes as from the dry and rather wearisome details of uninterrupted successes. I can quite understand that to those of us who do occasionally have failures and who do sometimes make mistakes, the record of never-ending success in others is apt to induce a rather irritating and pugnacious spirit. I trust, therefore, we may be occasionally cheered and comforted by a story of failure and a confession of error. I know that it requires a little courage to stand up in such a society as this and make a public confession of this sort, but common honesty requires the sacrifice,

and depend upon it those who make it have their reward in the satisfaction of knowing that they have done something to prevent the repetition of such error or failure in others; besides, it is not improbable that courage of the kind I refer to may prove to be somewhat contagious. Let me give you an illustration from my own experience, and perhaps my example in this instance may have an attractive following hereafter, for I think you will agree with me in the opinion that if none but successes are ever recorded here, we may ourselves become rather weary and satiated with that commodity, and our Society will be in danger of the charge that it is unreal and untrue.

My story is this: Many years ago I was amputating, with the single-wire écraseur, a cervix uteri for hypertrophic *allongement*. No anæsthetic was administered, as experience had taught me that the operation was not a very painful one. I was, however, struck by the fact that this patient suffered a great deal of pain, which I thought was due rather to her cowardice than to any fault of mine. It is, I suppose, human nature to imagine that if anything seems to go wrong it is no fault of ours. The first day or two after the operation there were more than the usual symptoms of irritative and inflammatory fever, suggestive, indeed, of peritonitis; and on the second day there was incontinence of urine. On the third day an examination was made to discover the cause, when a condition was revealed which led me to examine the specimen of amputated cervix, which I had ordered to be preserved as a good illustration of the disease for which the operation was performed. I then discovered that the specimen also illustrated something else, for on one side of the cut surface there was a portion of the unfortunate patient's bladder about the size of a shilling; and on the other side of the same surface a piece of peritonæum from Douglas's pouch of about the same dimensions. Hence were explained at once the incontinence of urine and the inflammatory fever of the first few days following the operation. I had afterwards the satisfaction of successfully performing on this patient an operation

for the cure of vesico-vaginal fistula. She was discharged perfectly well and happy, leaving me a sadder but a wiser man. The end of my story is that I detailed the case, and showed the specimen at the Obstetrical Society, thus illustrating what, I hope, may sometimes happen here, the record of a failure and a mistake. On that occasion I had the satisfaction of hearing the late Dr. Marion Sims and other equally competent operators affirm that my experience was by no means unique, for the same thing had occurred to them, only they had not previously the courage to declare it. I need hardly say that since that time I have been much more careful to see that neither the bladder nor the peritonæum is in the way of my écraseur, and many times I have been obliged to decline operation in these cases because I found it could not be done without this accident occurring.

And here I am reminded of another topic upon which I wish to make a few remarks, namely, the claim of the gynæcologist to the surgical treatment of all cases of disease, malformation, or other abnormal condition of those organs with which he has specially to deal. Of course those practitioners who do not choose to operate in the cases to which I have referred are not compelled to do so by any consideration, moral, ethical, or utilitarian; some of them, perhaps, would not be very successful if they did. But their refusal cannot for an instant affect the rights of those who take an opposite view of their duty, and who honestly and conscientiously fail to recognise either the logic of the position taken up by the former, or the right of those who, practising pure surgery, as they choose to call it, refuse to the gynæcologist the right to operate upon the uterus in one case, while they concede the right in another. It seems to me utterly absurd and illogical to expect the obstetric teacher to lecture upon the Cæsarian section, for instance, and to describe minutely all the steps and details of the operation, and yet refuse to allow him to operate. I am not aware that at present this operation is described in any text-book on surgery, whereas it certainly is described in all works on practical or operative midwifery.

The same remark, I believe, applies to such operations as ovariotomy, the removal of uterine fibroids, and the extirpation of the uterus; no work on general surgery with which I am acquainted gives any description of these operations, which every work on gynæcology which aims at completeness does. Surely, then, it is for the gynæcologist, and not for the surgeon, to treat such cases. Again, how absurd it seems to permit the obstetrician to operate upon cicatrices of the vagina where they obstruct the progress of delivery in childbirth, and yet not allow him to close up an opening into the vagina from either the bladder or rectum. If it be legitimate to perform the one, it cannot be wrong to do the other; certainly not as a matter of principle, still less on any logical pretext. Conventional rules may, of course, be framed on hard and fast lines, but they cannot command the assent of reasonable men unless they are framed on a reasonable basis; and to say that I may restore a ruptured perinæum if there be a resultant prolapsus uteri, but that I may not do the same operation if the sphincter ani is torn, and fæces incontinently prolapse, is certainly neither reasonable nor right, and as such must be rejected. The truth is that the whole spirit of the times is against these restrictions, and the generation of gynæcologists who are coming to the front will not tolerate such limitations of their just rights; they know that their moral position is a strong one, and that there are sound scientific reasons for the claim which they advance to have full right to treat all the diseases and abnormal conditions of the female generative organs, no matter whether the scalpel or the pen is the instrument required. Such is the position which this Society will, I am sure, maintain and enforce on the question at issue, and I cannot doubt that in time the profession will recognise the wisdom and justice of the claim, even if they do not admit it now.

These, then, are some of the reasons which seem to me not only to justify, but to require, the foundation of this Society, and I sincerely hope that in our work and conduct here we shall keep these aims steadily in view. I would venture also very earnestly to impress upon all those, especially

our younger Fellows, who intend to take a prominent part in the practical and scientific work of the Society, to strive to make their work such as shall be permanent, redounding not only to their own credit, but, what is of far higher importance, work which, while adding to the total sum of human knowledge (and only permanent work can do that), shall at the same time diminish the amount of human suffering, and even add to the duration of human life. And surely we need not go far to seek for materials upon which labour may be well expended. Questions of the deepest importance seem to crowd upon the mind when we begin to think of the work there is to do; and though gynæcologists may well be proud when they contemplate the triumphs which their art and science have won during the past quarter of a century—triumphs far exceeding those which any previous century has produced—yet I feel confident that a still more brilliant future is before us, and that further triumphs have yet to be won in the department of gynæcological surgery. Certain it is that operations are performed now which only a generation ago were never dreamed of, and which, when first suggested, were denounced as not only unscientific, but even immoral; yet these are now performed with an amount of success which contrasts favourably with any other capital operation. I venture to assert that greater advances have been made in this department of surgical practice than can be claimed by what is called 'pure surgery' within the same period, and I believe that the 'pure surgeon,' as he is sometimes rather strangely called, has learned much from the operating gynæcologist, however unwilling he may be to recognise or acknowledge it. Nor, I think, can it be doubted that the gynæcologist who performs all the operations which properly belong to his department has added vastly more to our stock of knowledge, and done far more for the good of mankind, than he who either cannot or will not perform them. I may also, I believe, go further, and say that, as a matter of fact, whatever the explanation may be, the operating gynæcologist is far more successful with his operations than when they are

performed by the general or pure surgeon; and as regards the performance of such operations as ovariotomy, or for other abdominal tumours, I question whether it is wise that these should be attempted in the wards of a general hospital, as is, I know, sometimes done. Our gynæcological triumphs were certainly not won under such circumstances, and I am quite sure we could not maintain them in the like conditions.

I lately read with much interest the inaugural address of the President of the Clinical Society, Mr. Thomas Bryant, and was struck by his earnest appeal to his medical brethren, the physicians, to aid the surgeons in the matter of diagnosis, especially in cases within the domain of abdominal surgery. Such an appeal seems to me yet further to strengthen the claim for which I am contending, for if the gynæcological physician possesses in an especial manner, as the result of his special experience, the faculty of diagnosis in abdominal cases, as I fully believe he does, surely, if he be an operator at all, he ought to be allowed to operate in cases of this sort. By so doing, he will not only quicken his diagnostic skill, but his operations will probably be more successful, as his knowledge of the diseases of the parts operated on is more precise and intimate.

Of late years physiology has been more prominently associated with some of our surgical work. The operation of ovariotomy in cases of uterine fibromas is proof of this proposition; for is it not true that the justification for this operation in the cases referred to is based entirely on the physiology of the subject? If the function of the ovaries be not the chief factor in the growth and development of those tumours, then I do not see on what ground the operation for their removal is founded. And here I am reminded of a physiological question which surely ought to be settled by such a society as this, viz. the influence of the ovaries and the effect of ovulation in the production of menstruation. It is no doubt well known to you that one of our most distinguished Fellows, and certainly one of our most brilliant operators, Mr. Lawson Tait, denies that the ovaries have anything to do with the

function of menstruation, at least in originating that act. There must be plenty of evidence now to determine this question, and a small working committee to collect and sift this evidence and present it to us for discussion and criticism would, I think, be doing a very useful work, and one peculiarly appropriate to the objects of this Society.

Another question which we ought to be able, with our vast opportunities for observation, finally to determine is the value of the so-called antiseptic mode of operating, and more particularly the use of the carbolic spray in abdominal surgery. I mention this specially because I suppose there are no operations equal to that of opening the abdomen in which the alleged value of the spray could be more thoroughly tested and appreciated. I believe there is no other society in existence which can bring to bear upon this question such a vast array of surgical experience. We have already in our ranks some of the most practised operators in abdominal surgery, and our combined experience would surely be sufficient to determine such a question as this, for I suppose that the clinical experience of this Society, estimated by the total number of beds in our special and general hospitals which are held by the Fellows of this Society, far outweighs that of any other society. It is this fact, I take it, which will give such weight to our discussions on disputed gynæcological topics, and which must necessarily command attention and respect. All this, however, only makes it the more important that the opinions we express and the judgment we form should be most carefully thought over, and be the result of calm, unprejudiced observation at the bedside ; if otherwise, then our discussions will be only misleading, and our experience nothing less than a delusion and a snare. On this topic of antiseptics, so far as the carbolic spray is concerned, I must confess that my own experience is decidedly adverse. I have tried and tested it most carefully, and so unbiassed was I when I began this practice, that for a time I was strongly and favourably impressed with it. I thought that many of the cases of ovariotomy and other abdominal sections which I performed, some

of them of a particularly severe and dangerous kind, and many of them performed in a general hospital, though under the most favourable conditions, owed their success chiefly to the spray; but at length, feeling the inconvenience of operating in a fog, especially in London in dark November days with a still worse fog outside, I abandoned the practice, and found that my success was quite as great without as with the carbolic spray. Accordingly I have now quite given up this mode of procedure, not only in private but also in hospital work, where if anywhere it might be thought that it was most urgently called for and would show the most satisfactory results. I am bound, however, to say that I do not think the carbolic spray exercises the smallest beneficial influence, while I am painfully aware of its great practical inconvenience.

Speaking of ovariotomy, I am reminded of another question of much importance about which I think we have now sufficient experience to enable us to give a clear and decided opinion, viz. as to the best mode of treating the pedicle. I have been an ovariotomist long enough to have seen all methods adopted, including clamp, cautery, and ligatures of all sorts. I have tried them all myself, and I speak with the experience of nearly 500 cases when I say that I am a strong opponent of the clamp, and a very lukewarm supporter of the cautery, for the simple reason that I have lost cases from subsequent hæmorrhage from the stump, and that I have had to tie bleeding vessels after its use, whereas with the ligature no such accident has occurred, and I cannot remember any case in which evil has resulted, directly or indirectly, from its employment.

I have already incidentally alluded to the operation of ovariotomy in the treatment of fibroid tumours of the uterus. This is a subject which is at present quite in its infancy, and no doubt the Society will watch over its growth and development with keen interest and pride, for I cannot but think that a great future is opened up by this operation, which is of far-reaching significance and importance. We must, however, obtain accurate information of the physiology of those

organs before we can fully determine their pathological tendencies, or gauge the full measure of the therapeutical value of their removal; for it is probably not only in the surgical treatment of uterine fibromas that ovariotomy is destined to play an important part, nor is it merely for organic diseases of the uterus that removal of the ovaries may be required. Are there not some affections of the nervous system in women which we can trace distinctly to morbid ovarian action, and which hitherto medicines have entirely failed to cure? cases of a peculiarly distressing kind, which render life almost unbearable, and in which this operation seems to hold out a reasonable hope of success. Here, again, I think our Society offers the best field for determining this question, and we may look at no distant date for a record of success in this direction. Besides this, experience is no doubt daily accumulating as to the value of ovariotomy in the treatment of uterine fibroids; one such case is at present under my care in which the results so far are most satisfactory; and I have had three others in which success was complete and undoubted, the tumours almost entirely disappearing, and their distressing symptoms subsiding within a short time after removal of the ovaries; in two of them menstruation ceased immediately after the operation, and in one it only recurred twice.

In close connection with this subject reference should also be made to the wonderful success achieved by Mr. Lawson Tait in the operation with which he has made us familiar, viz. the removal of the Fallopian tubes. I feel sure that when the diagnosis of the cases in which this operation seems called for is made a little clearer by further experience, we shall have placed in our hands a method of treatment which is singularly successful, and which marks one of the greatest advances of modern times in gynæcological surgery.

It is, perhaps, too much to hope or expect that this or any other society will be able for many a long year to settle the disputed questions connected with the so-called mechanical system of uterine pathology. I refer more especially to the

legitimate, scientific, and therefore successful employment of pessaries, or other mechanical treatment for the various forms of uterine displacement. And yet I cannot help thinking that if we could approach this subject in a purely scientific spirit, with minds absolutely free from any intentional bias, viewing it as a question to be determined only by clinical observation, with a minute appreciation of facts, and a thorough knowledge of physiological and pathological processes, surely there could not be much difficulty in determining where the truth really is, and so putting the whole matter on a sound scientific basis, with the certainty of success, and with a freedom from that opprobrium which I fear attaches to the question at the present time. It can neither be to the advantage nor to the credit or dignity of our branch of medical practice that this question should remain as it is, for both the public and the profession alike have the impression that mechanical treatment, and especially the employment of pessaries, is far too frequently resorted to in cases of uterine displacement, and sometimes even where no displacement exists. It behoves us all, therefore, to try and remove this impression, which I believe is, for the most part, unfounded, by exact scientific methods, by careful clinical observation, and by the application of sound principles of pathology.

Turning now from the surgical or mechanical aspect of our department, many questions present themselves for consideration from the purely medical side, and I would fain hope that the experience of the Fellows of this Society will be so recorded that our medicinal treatment of some of the diseases of women will be put upon a much more exact, more certain, and more successful basis than exists at the present time. We know already that some drugs have a specific action upon the uterus; others again upon the ovaries. But the list of these known drugs is far too small, and it ought, I think, to be considerably increased. We have many drugs that act specifically upon the liver, the bowels, the kidneys, the skin, the salivary glands, the heart, the spinal cord, &c. Why should we not have an equally numerous list from

which to select when we come to treat the uterus or the ovaries? At present, it must be confessed, we are lamentably weak in this respect, but surely the work of this Society is not to be merely a record of surgical experience; we want especially to enrich our therapeutical knowledge, and this can only be done by careful clinical observation, by accurately recorded symptoms, both of the disease itself and of its modification by treatment, so that, if possible, we may deduce therefrom some broad generalisations.

I hope in the coming year we shall have many accurate histories of exact therapeutical observations, so that our first year of existence may add distinctly to the treasury of useful knowledge from which our professional brethren may draw for the benefit of those who may come under their care.

There are a few drugs certainly which we may regard almost in the light of specifics in certain diseased conditions of the female generative organs; at all events their physiological and therefore therapeutical action is perfectly well known and understood. I have already alluded to the physiological action of ergot; and my experience leads me to regard quinine and nux vomica as possessing similar powers. If, as I believe, we may regard the physiological action of any drug as determining its therapeutical value and property, what we want is exact physiological experiments tested by clinical observations. There can, I suppose, be no doubt that ergot acts directly upon the involuntary unstriped muscular fibre wherever it is met with; that its action therefore is by no means limited to the uterus, and that it has a very distinct effect upon the muscular coats of arteries and capillaries; hence in poisonous doses it causes such contraction of these vessels that the blood is driven into the veins, which accordingly become distended, and the patient assumes quite a livid hue. This phenomenon I have observed again and again, and the explanation must, I think, be that which I have just given. Here, then, we have a fact which might be turned to therapeutical account.

As an example of a pelvic anodyne, with special reference

to the ovaries, I know of none that can compare with conium, or, better still, with the alkaloid conia, used in the form of vaginal pessary. In all cases, whether neuralgic or inflammatory, in which the ovaries are the seat of pain, conia is, to my mind, quite a specific. No drug that I know of acts with equal certainty and success. Lastly, I suppose we are all agreed that bromide of potassium exercises most powerful influence upon the ovaries. No drug, in my experience, can equal it in controlling ovarian menorrhagia; it not only limits the flow in these particular cases, but it seems also to exercise a distinct and controlling influence upon ovulation itself. Hence, if Mr. Lawson Tait will allow me to say so, its value in checking ovarian menorrhagia, so far as regards its too frequent periodicity, for it certainly increases the length of the menstrual interval; in other words, it controls too frequent menstruation, or, as I should say, too frequent ovulation. Now, we want more of such remedies as those I have mentioned, remedies which we can prescribe with almost absolute knowledge of their therapeutical value and effect, and we may look to the experience of the Fellows of this Society to supply many more examples of this kind. It will be by papers on such subjects, giving us exact experiments and observations, more probably than by the record of our surgical experiences, that this Society will fulfil what I hope may be regarded as one, if not the chief, of its functions, viz. to educate the mass of our professional brethren in the therapeutical branch of their calling in these particular cases. Nothing, I think, could more fitly demonstrate its utility than the record of such experience, and such work as this would, I am sure, earn and receive the gratitude both of the profession and the public.

Gentlemen, I trust you will forgive me for having detained you so long. I have endeavoured as briefly as I could, and I know very imperfectly, to give a slight sketch of the work and office of this Society, as the subject presents itself to my mind. No one, I think, will venture to deny that, with such objects in view, the founding of this Society, if it be true to its mission,

is a great and useful work. I earnestly hope that in all our discussions we shall ever keep in view this primary purpose, and that we shall meet here with the ever-present consciousness that our work is not only scientific, but noble and grand, as all truly scientific work is, and must be, from the very nature of the case. I trust that the brilliancy of our discussions will never be tarnished by personalities, and that we shall ever bear in mind that criticism in matters of opinion, be it ever so sharp and incisive, is not a matter which need or should give any personal offence. He who feels offended at such criticism is thinking more of himself than his work; be it ours to think more of our work than ourselves; so that when we shall have passed away our work may still live on, and do good suit and service in the cause of suffering humanity; for then, assuredly, we shall not have lived and worked in vain.

Dr. BARNES, in moving a vote of thanks to the President for his excellent address, said it was superfluous to point out how admirably the purpose and prospects of their new Society had been set forth. Its existence was a necessary condition of the progress of gynæcology in this country. As an illustration of the difficulties under which the study was pursued in London, he would refer to what took place in a large hospital when the obstetric physician was compelled to call in the surgeon to operate. It was a question of opening a retro-uterine abscess. The obstetric physician introduced the trocar into the vagina, and, when in accurate position, gave the word, 'Now!' The surgeon then performed the operation by pushing in the knife. This example, ridiculous as it seemed, aptly illustrated the absurdity of the arrangement which compelled the obstetric physician to turn over the treatment of his cases to other hands at the moment of greatest interest.

The President had pointed out that the first presidents of the Obstetrical Society, Rigby and Tyler Smith, had laid down a strictly obstetrical programme. Dr. Barnes, however, who succeeded Tyler Smith, had, in his address, distinctly

included gynæcology in the work of the obstetrist in laying down the following proposition :—'The work of the obstetric physician embraces the treatment of the diseases of the female generative organs, including the disorders and lesions, general and local, which result from pregnancy and parturition.'

Mr. LAWSON TAIT said: I second the proposal which has just been made by Dr. Barnes, at the request of the two Secretaries, and I do so with very great pleasure, though there is some difficulty in feeling that I have been alluded to in the address in terms that are so gratifying. I think our new Society is to be congratulated on having chosen for its first President one so distinguished as Dr. Meadows, and we have every reason to be satisfied with the judicious scheme which he has drawn up for the guidance of our early career. He has alluded, in language which is most carefully considerate, to the proceedings of another society, upon which strong comments might be made, but which perhaps had better be passed by simply with the statement that many who hear me speak will quite understand what I mean. The justification for this new society is precisely that which existed for the formation of the Obstetrical Society some five-and-twenty years ago. Many distinguished men who practised obstetrics at that time became convinced that their arts had achieved a scientific position and so great an excellence that it demanded a public recognition. The result was the establishment of the Obstetrical Society, marking the definition for all time of obstetrics as a distinct branch of our profession. Precisely the same thing has occurred again. The enormously rapid progress which has been made by gynæcology and its great scientific achievements demand alike a public recognition. The establishment of this Society again marks the definition of this kind of practice as a distinct department of professional culture. Our President has clearly indicated the need for this movement in his criticism of the proceedings of the Obstetrical Society. It has been to myself frequently a cause of no small annoyance to find

that a subject introduced before that society, either by myself or some other, upon which the possibilities of advance were so great that the whole attention of the Society ought to have been concentrated upon it, passed by without comment. The next paper perhaps would excite the greatest interest and lead to an animated discussion, and yet it might consist of nothing more than an antiquarian research into some eccentric and wholly unimportant form of pelvis. The time has come when this must be mended, and the brilliant gathering which I now address, the very large number of Fellows who have already joined the Society just announced by the President, the clear, wholesome, and liberal line of policy adopted by your new code of laws, alike augur well for the success of the British Gynæcological Society.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, MARCH 25th, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

Mr. LAWSON TAIT showed a specimen of a large, soft, œdematous myoma which he had removed six days before from a lady aged fifty-three. The patient, unfortunately, did not recover, but had made a most gallant effort to do so, and had succumbed apparently chiefly by reason of the previous exhaustion from hemorrhage. The case was an extremely interesting one, and indicated an entirely new departure in several respects, some of which were of great importance. In the first place the case illustrates the fact, which is now becoming very fully recognised, that the growth of such tumours prevents the occurrence of the menopause instead of the occurrence of the menopause arresting their growth. The patient in question had been under the care of a distinguished London physician for about two years, and he had apparently watched the growth of this tumour to an immense size without being aware of the necessity for surgical interference. This was at last forced upon the case by the occurrence of hemorrhage so alarming that it brought the patient to death's door. When Mr. Tait first saw her, ten days ago, there was no possibility of any kind of interference, on account of the imminent risk of death. When an examination was made, a large mass was found presenting through a dilated os, round which the cervix could be felt thinned, and it extended over the mass precisely as in labour. There were also distinct rhythmical uterine contractions. It was perfectly clear that

the mass was too large to pass by the vagina, and Dr. Matthews Duncan was therefore summoned to consultation to determine whether it might be possible, in the event of the patient making some attempt at recovery, to perform hysterectomy, and in this view Dr. Duncan quite concurred. The patient rallied very materially for a few days, but hemorrhage again set in, and it became absolutely necessary to seize the opportunity for operating if anything were to be done at all. Hysterectomy was therefore performed, and the pedicle had to be made very much after the fashion of a huge egg-cup, or like the flap in a circular amputation. The tumour when removed was over eighteen pounds in weight, and was a large, uniform, oval mass.

Dr. ROUTH said he felt indebted to Mr. Lawson Tait for the novelty of his procedure in his interesting case. He should like to know whether in all those cases where a very large polypus was either wholly or partly expelled into the vagina so as to fill the pelvis, he (Mr. Lawson Tait) would recommend removal by the abdominal section. He (Dr. Routh) had seen two cases where the question might have arisen. The first was that of a Spanish lady, a patient of Mr. Baker Brown's, in whom such a fibroid polypus as big as a man's head had been forced into the pelvis. In the centre was a depression, into which a sound could be introduced six or seven inches. Mr. Brown had thought this was the uterus, but Dr. Routh was enabled with great difficulty to feel on one side a piece of the rim of the os uteri. He removed a large portion of this tumour with the écraseur, intending to remove the remainder the next day, but in the night she was seized with tetanus and died in a few hours. The other case was that of a lady with a large fibroid, polypoid in character, quite as big as a boy's head. Under the influence of ergot, he checked the hæmorrhage, and forced the tumour out into the vagina. He had given directions that the moment this occurred he was to be told. This was not done, however, and a local doctor was called in who did not recognise the condition. It was not till the week after that he was sent for. The tumour

was then in a state of sphacelus, and the whole house smelt worse than the dissecting-room. She was also in a collapsed state. He tried to rally her, injecting antiseptics round the tumour in the vagina until she became sweet again, and ordering food and stimulants, and desiring that the moment she rallied she was to be brought to town. She did rally in two or three days, and he proceeded, in connection with Drs. Rogers, Wynn Williams, and his son—the last of whom administered ether—to endeavour to cut away the tumour with the écraseur. Three times the écraseur wire broke, and, unfortunately, though he managed to get away a large portion of the tumour, the patient suddenly died. Now he (Dr. Routh) wished to know whether in a case like this Mr. Lawson Tait would have advised abdominal section for the removal of the tumour and uterus. He (Dr. Routh) feared septicæmic poisoning would be the result, and even in Mr. Lawson Tait's case there seemed to be a slight suspicion that there might have been also a little sepsis, perhaps, in the case.

Dr. BANTOCK regarded the specimen of uterine fibroid with great interest, for it came most opportunely to illustrate the remarks he had ventured to make at the last meeting, when he urged the importance of not delaying surgical interference until the patient has been reduced to the last extremity, as in this case. No doubt, many cases had been sacrificed in the same way. This case reminded him very much of one he had seen two or three years ago. The tumour was very large, extending into the epigastrium, and projecting into the vagina, and involving one side of the cervix. Removal by the vagina would have been impossible, because of its enormous size, while the general condition of the patient was very good, and there were no symptoms calling for interference by such a dangerous operation as hysterectomy by abdominal section would have been. The result of the case was that, a few months after my last interview, a severe flooding came on, and the patient died forthwith from the loss of blood.

Mr. LAWSON TAIT, in reply to Dr. Routh, said that his own experience had been extremely fatal in attempting to remove large presenting masses of myoma by the vagina. He could not say with any accuracy how many times he had operated in such cases, but it probably was ten or twelve, and he could only call to mind one case of recovery, the recovery in that instance being an extremely narrow issue. He was now entirely averse to attempting to remove any such presenting mass by the vagina unless it had entered the pelvis. In that must be the gauge that it might be cut to pieces and removed with a reasonable amount of risk. In all other cases he was quite satisfied that hysterectomy performed early in the case would give a far better chance for the patient. He also had to say that he entered a most earnest protest against the delay which was fashionable at present in those cases, for it gave results which were neither advantageous to the patients, beneficial to the practitioner, nor creditable to the art which we practise. In such a case as the present it was possible that removal of the uterine appendages two or three years ago might have arrested the growth of the tumour, and hysterectomy performed before the onset of the severe hæmorrhage certainly must have had a successful result.

Dr. EDIS then showed, for Dr. Burton, of Liverpool, a case of abscesses of both ovaries. Mrs. P., *æt.* thirty-two, married ten years, had three children, the last five years ago, no miscarriage, had been under Dr. Burton's care, off and on, for four years. When she first came under notice she was suffering from a deep bi-lateral laceration of the cervix uteri, so deep, in fact, that the cervix resembled two ripples springing from the vaginal roof. The uterus was fixed so that it could not be drawn down, as was shown in an abortive attempt at trachelorrhaphy. She was also suffering from periodical rigors, at intervals of from four to six weeks, followed by high pyrexia, sometimes up to 104, and a pulse of 150. Feebleness and pelvic pain were constant symptoms. She remained in this state, sometimes a little better and

sometimes worse, for over three years, and was frequently seen by Dr. Burton, or his colleague, Dr. Davies. Last year (November) she was admitted as an in-patient into the Hospital for Women, Liverpool, for the purpose of again attempting trachelorrhaphy, and Dr. Davies succeeded in restoring one side. The operation was speedily followed by a fresh attack of pelvic cellulitis, the infiltration extending to about two inches above the pubes. She remained in hospital under general treatment—poultices, iodine to the abdominal walls, sulphide of calcium, &c.—until the early part of the present month, when Dr. Burton at last made up his mind to do what he had always been afraid of, *i.e.* remove the uterine appendages. He could not forget that para- and perimetritis had followed both previous operative measures; that rigors and pyrexia were periodical, and that the pulse was sometimes at 160, and never below 120.

At this time there was a large fluctuating swelling to the left of the uterus. This he took to be an abscess of the left broad ligament. On March 2, the abdomen was opened. A large soft fluctuating swelling was felt and soon brought into view; he still thought it in the broad ligament, could feel the Fallopian tube running over it. The aspirator needle was now plunged into the cyst, and about 3 oz. of fœtid pus were withdrawn. He then turned to the right side, and found the appendages matted together and to the pelvis walls, and, after some difficulty, succeeded in freeing, ligaturing, and removing them. He now again returned to the left side, and, after some strong pulling, freed the cyst and tubes, and removed them. On examining after removal, the left ovary was found to be the seat of a large abscess, having a thick loose pyogenic membrane, and the right of several smaller abscesses, showing out beautifully on section. Both Fallopian tubes were enlarged, and contained caseous-looking matter dotted here and there on the walls.

The same evening the patient's pulse fell to 100, and never rose again during the whole course of recovery, which was uninterrupted, notwithstanding considerable difficulty

in removing the drainage tube on the third day, from the omentum flowing into the two upper holes of it, and rendering it necessary to draw it out of the abdominal cavity before it could be loosed from the holes with the fingers. Up to the present date, March 21, she has had no return of rigors or pyrexia. From a prognostic point of view it would be interesting to learn whether the cheesy matter of the tubes is tubercular. The extreme rarity of abscesses of the ovary makes the case one of great interest.

Dr. EDIS concurred with Dr. Burton in the opinion that abscess of the ovary was comparatively a very rare condition.

Mr. REEVES showed a bladder from a young woman which had become perforated through an ulcer and occluded by omentum. She was admitted for incontinence, and on examination the parts were found excoriated, and a urethral polypus was detected. This was removed, and the bladder digitally explored. An assistant, in passing a sponge or holder, observed that it could be passed a considerable distance, and on its withdrawal, myxomatous or fatty-looking masses were exposed which were thought to be polypi. There was much pain in hypogastrium the next day, and peritonitic symptoms supervened and proved fatal. The autopsy revealed an old ulcer at the left posterior and lower part of the bladder. This had been plugged by omentum, which was still adherent to a part of the circumference of the perforation. The introduction of the sponge had separated a part of the adhesion, and also led to a partial hernia of the omentum into the bladder as the sponge was withdrawn. The extreme rarity of the case and its circumstances make it unique, and justify its being placed on permanent record in the Transactions of our Society. On microscopic examination the urethral polypus was found to be a glandular papillary growth. As the bladder was much contracted, digital exploration, with the view of ascertaining the cause of the incontinence, was called for, and, though it is true that this accidentally led to a catastrophe, still no other course was open to any one desirous of ascertaining the real condition of affairs.

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Dr. BARNES had distinct recollection of two cases of fistulous communication between the bowel and the bladder. In one case it probably arose as a consequence of ulceration from typhoid. In the other case, fæcal matter passed with the urine was examined for him by Dr. Ord, who always gave him an accurate account of what the patient had eaten; autopsy was performed by Mr. Croft. A malignant ulceration, which seemed to have begun in the small intestine, had extended to the bladder.

Dr. AVELING said that pathological openings in the bladder were not very uncommon. He had lately met with a case of intestino-vesical fistula in a patient in the Chelsea Hospital for Women, which he had endeavoured to close by applying the galvanic cautery.

A paper was then read by ROBERT BELL, M.D., Physician to the Glasgow Institution for Diseases of Women and Children, on 'Dysmenorrhœa':—

Few subjects have given rise to a greater amount of discussion, and have evolved a greater diversity of theories, than that of menstruation. When one attempts to wade through the plethora of literature which treats of its cause, its source, its effects on the individual, &c., he will speedily ascertain that he has set himself a task of no mean difficulty, and when his labour is completed he will find that he is probably more at sea than when he commenced his more extended investigations. I confess I hardly thought it possible such a variety of opinion could exist upon any subject, and I fear it is nothing short of presumption on my part to attempt to speak on a theme which has exercised the thought and ingenuity of so many able and eminent members of our profession, the result, however, to my mind being that as yet no definite and generally accepted theory has been established. My object, then, to-night, is to offer for your consideration, if not your acceptance, views which have for years been becoming more and more established in my mind, and which have for long dictated the line of treatment adopted by me. As we cannot disassociate the catamenia from dysmenorrhœa, it

will be desirable, at all events, to devote a few minutes to the physiology as applied to the pathology of menstruation. All seem agreed that the discharge of blood which constitutes the menstrual flow proceeds from the lining membrane of the uterus. I have employed the term *lining* membrane in preference to that of the generally accepted *mucous* membrane, as I am very much inclined to think, with Emmet, that it is not strictly speaking a *mucous* membrane. It neither harmonises in its structure nor its behaviour with any mucous membrane. It seems to me to partake more of the character of the granulating surface of a healing sore than any other structure, and, like healthy granulations, it partakes very much of the nature of a soil on which epithelium grows, instead of it becoming an essential part of the tissue, as is the case with the epithelium covering a mucous membrane. Mark me, I do not aver that it is composed of granulations, but I do hold that it resembles this growth in a great many important points. For example, the lining membrane of the uterus, like granulations, is very vascular and spongy, and therefore bleeds with little provocation. It is easily destroyed and readily renewed. Its vitality is less than that of a mucous membrane, and in this it again resembles granulations. In fact, there is hardly a particular in which the two growths do not agree. When menstruation of the Graafian vesicle occurs, hyperæmia of the uterus takes place as a physiological sequence, being a result of the increased activity in the ovary. This hyperæmia stimulates the cell life of the lining membrane of the organ, and a great proliferation of its cells is the result. These naturally are renewed from within outwards, and in consequence the superficial layer is shed during the prevalence of the hyperæmia. With this desquamation of the outer layer of the membrane the capillaries are ruptured, and hence the flow proceeds. The hæmorrhage in its turn acts as a depleting agent, thus relieving the congestion, which therefore gradually subsides, and the period passes away. When this epoch of congestion has terminated and the equilibrium of the normal blood supply is again esta-

blished, we find the lining membrane quite renewed, and capable of becoming the nidus of an impregnated ovum. Now, as impregnation usually takes place shortly after the cessation of the menses, it is very appropriate that the ovum should be received into a newly matured and therefore more vigorous receptacle. We must not forget, however, to notice the important part the utricular glands play in this monthly *rôle*. When the superficial layer of membrane is exfoliated, naturally the epithelial covering goes with it, but this is speedily renewed, when the process is complete, by prolongation from the epithelial lining of these innumerable glandular apertures. An analogy to this can frequently be demonstrated when a superficial sore has been formed, and where the granulating surface heals over with amazing rapidity, each little cutaneous gland giving rise to an island of epithelium, which speedily coalesces with its neighbours, and completes the healing process. If we carry the analogy a little farther, and enter just within the regions of pathology, we will see in how many instances the two surfaces resemble one another. It is a curious fact that epithelium will not extend its growth up an incline. It must have a level surface to develop itself upon. We observe this in sores where the granulations are too prolific. Who ever saw what is commonly known as proud flesh covered with epithelium? No, the redundant growth must either atrophy or be destroyed before we get this result. So with what we designate fungosities of the uterus, which are neither more nor less than an exuberant growth of the lining membrane, and which, moreover, are not covered with epithelium; hence a constant oozing of blood emanates from them. As soon as these are destroyed, the bleeding ceases, the lining membrane becomes covered with epithelium, and the bleeding orifices close. I hope, gentlemen, you will pardon me dwelling so long on one view of the natural history of this membrane, but as it appears to me to be nearly correct, my conclusions are naturally based upon it, therefore I have ventured to give you the result of my observations as briefly as possible. I have

done so because I may frequently have to refer to this hypothesis in the course of my further remarks.

We must bear in mind that the uterine canal in health is not to any extent a secreting cavity; I refer, of course, to that portion above the internal os. As we all know, the cervical canal secretes a glairy mucus peculiar to itself. We then have the fundus and body in the healthy condition quite inactive (if unimpregnated), except at the monthly epochs. If, therefore, a discharge is observed oozing from the os which differs in character from the cervical secretion, it would suggest the presence of disease, but as any discharge which is not really cervical is apt sooner or later to become purulent, there can then be no difficulty in indicating its source.

If normal menstruation is simply a disintegration of an old stratum of cells which have been thrown off because a more recent and therefore a stronger substratum has taken their place, the older layer degenerating in consequence of their cell-growth being over-stimulated by the monthly hyperæmia, we can understand how this monthly wave produces the menstrual flow in health. So far, however, I have not really touched upon the subject I came to discuss, and before I do so, I must still further crave your indulgence, as, with your permission, I would like to say a few words about the discharge itself.

The menstrual fluid, I think, on all hands is acknowledged to consist of blood mixed with the *débris* of the exfoliated lining membrane. Now it is a well-established fact that blood in contact with a healthy membrane retains its ability to remain fluid, but if it comes in contact with a foreign body, this imparts to the blood a newly-acquired property, which enables it to separate into two distinct substances, each of which differs from blood itself, viz., clot or fibrin and liquor sanguinis or serum. This no doubt is the result of a vital action on the part of the blood, induced by contact with a foreign body. Were it not for this endowment, and the capability of the clot to become organised when it remains in contact with vascular lining tissue for a length of time, hæmor-

rhages would not spontaneously cease as they tend to do. Now we know that a tissue, whose vitality is impaired by inflammation, acts on blood as an irritant and induces coagulation. Likewise, if the vitality of a tissue is reduced by an injury, this catalytic effect is produced by the injured part. We can perceive, then, so long as the lining membrane of the uterus remains healthy, the blood will tend to remain fluid and thus no pain will result from the actual evacuation of the discharge, because it will ooze away without difficulty; that is to say if the os is patent. We cannot, of course, designate the periodic engorgement of the uterine tissue as disease, when it *completely* disappears with the cessation of the activity in the ovary, any more than we can call the condition of the stomachic mucous membrane, which induces the sensation of hunger, congestion. If, however, the loading of the blood-vessels goes beyond the physiological stage, and inflammation more or less active is the result, an irritant of greater or lesser intensity presents itself, which according to its intensity will act more or less energetically in inducing coagulation. The clots which result will therefore require an effort on the part of the uterus to expel them, and, moreover, the contraction of the walls of the organ will produce a degree of pain relative to the degree of hypersensitiveness which the amount of inflammation entails. The pain, then, is not due entirely to the circumstance that, instead of fluid flowing freely away, a clot, or a series of clots, have to be expelled by a number of spasmodic efforts of the muscular walls, but also to the fact that those are in a condition of hyperæsthesia, their nerve filaments being already in a highly sensitive condition consequent on their compression due to the hyperplasia. If, however, the clots were not present, there would be comparatively little aggravation of pain at the molimen. We have this demonstrated in cases where there is a copious catarrhal discharge during the interval of the menses, but where the catamenial flow is alone accompanied by pain.

We therefore are led to look upon a tissue weakened by inflammation as a foreign body would be viewed, in so far as

it affects the blood. Yet this may gradate so gently and imperceptibly from the line which indicates health to that which points to disease in its most active and potent form, as to make it quite impossible to recognise a line of demarcation. It is, however, in the lesser degrees of inflammation that the discharge is most copious, and therefore the clots are both larger and more numerous than when the inflammation is more acute, but the intensity of the pain does not diminish in a like ratio. We may have a condition of the uterine walls which is certainly due to a form of congestion but which does not add *per se* to the hypersensitiveness of the organ. The result of this minor form of inflammation is hyperplasia accompanied by an œdematous condition of the tissues, arising from a partially obstructed venous return-flow. The result of this is naturally a feeling of weight and bearing down in the pelvis, and there is superadded an abundant catarrh, while the menstrual epoch is marked by a copious and clotted discharge often extending for days beyond the normal period. There is not always pain, however, because the uterus is flabby and patulous, and therefore the discharge escapes rapidly. On the other hand, however, there is frequently very intense suffering, and this occurs notwithstanding the patulous condition of the canal and its normal direction. The question naturally arises, how are we to account for the different symptoms observed? It is obvious, I think, that in the one case we have a simple œdema consequent on an interference with the circulation in the veins, whereas in the other we have the hyperplasia due to an inflammatory condition of an active type, where the effusive lymph is plastic and which therefore renders the tissues denser than when mere effusion occurs. Again, when inflammation exists the clots are more compact than when they are induced by contact with a merely weakened tissue. Moreover, the blood is more coagulable in the one case than in the other, and therefore a greater effort is required to expel these clots. Then we must not forget that the uterine walls are very much more sensitive in the latter case than in the former. It may be asked, how does

this condition of things not tend to spontaneous cure, or why does it not proceed to a more intense degree of inflammation? for we frequently come across cases which have continued for years in very much the same condition locally, though the strength of the patient has gradually been waning. The explanation is that the monthly depletion acts as nature's antiphlogistic, and the excessive catarrh also tends to relieve the overloaded tissues. On the other hand, we should not forget that the anatomical position of the uterus tends to promote any unhealthy condition of this nature, suspended as it is in the pelvis. If the tone of the muscular fibres is diminished, we can fully understand how the helplessness of the veins is increased, for while the arteries continue to pour blood into the organ, the veins which are destitute of valves become engorged and keep up the œdema in consequence of effusion of serum through their walls constantly going on. When this obtains it is of course impossible for the lining membrane of the canal to retain its health, as the cell-growth is overstimulated to such a degree that maturation of the cells never takes place, and they are cast off in large quantities, passing away along with a serous exudation, either as pus or a mucopurulent discharge, which is very copious and not unfrequently has imparted to it a fœtid odour. We thus have a degenerative lining membrane taking the place of the healthy, the consequence being that it readily breaks down at the monthly period and bleeds profusely, not only while the activity of the ovary continues (for the overloaded condition of the arteries persists beyond this), but for a time afterwards, varying from a few days to the whole period which ought to be that of cessation. When the discharge is so persistent as to give rise to menorrhagia or metrorrhagia, as a rule there is not much pain nor coagula either, for the reason that the bleeding relieves the congestion and the flow is so free that the blood does not remain long enough in the canal to permit of coagulation taking place then. If, however, the inflammation is more intense than this, the hæmorrhage is less and clots within the uterus are more numerous. This arises from

the irritant being more decided, and therefore blood-clots are more readily formed at the orifice of the ruptured capillaries. Nay, more, clots may and actually do form within the vessels themselves and thus arrest the hæmorrhage, which otherwise would relieve the congested tissues, but this not taking place effusion of lymph goes on into the parenchyma, becomes organised, and produces rigidity and tension of the uterine walls.

Such a condition of the womb is associated with acute hyperæsthesia from the compression which the nerve filaments endure, and consequently every movement of the body, and to a much greater degree every contraction of the uterine fibres, are accompanied by intense suffering. This pain, however, is not confined to the actual seat of the irritation, but radiates throughout the whole area supplied by the trunks of the nerves, of which these are the peripheries. Moreover, this congestion reacts on the ovaries through excess of blood pressure being thrown upon them by the surcharged ovarian veins, and through these the whole pelvic vascular system is disorganised, either by direct venous continuity or through the vasomotor nervous apparatus. When this condition of the uterus exists we have the menstrual discharge diminished in quantity, and that being exposed to a more intense irritant coagulates more rapidly, and is retained, because of its scantiness, for a longer period. It therefore necessitates a greater effort for its expulsion, and, the neurasthenia of the organ being acute, the pain bears a close relation to the size of the os. This, however, cannot properly be designated obstructive dysmenorrhœa, as many have named it, because, if the inflammation did not exist, in the majority of cases the os is quite patent enough to permit the discharge *of blood* to escape without pain. I will illustrate this by detailing a case which interested me very much. Mrs. K., *æt.* 28, consulted me in May 1883. She was married at 24; menstruated for the first time at 16, and continued to do so regularly and without pain till she was 20, after which she began to suffer at each catamenial period. This gradually increased in severity, and as it did so the discharge became more

and more clotted, till eventually a complete cast of the uterine cavity was thrown off at each period. This was always preceded by severe suffering, accompanied by a red, watery discharge, which continued for two days, when the pain would come to a climax and the cast be expelled. With this the pain ceased, though a few smaller clots would come away with some fluid discharge for another day, but with very little inconvenience. There was dyspareunia, also a copious mucopurulent discharge. Vaginal examination disclosed hyperplasia. The uterus was acutely sensitive to touch. When the sound was passed, the internal os was found to be spasmodically stenotic, and the canal beyond very painful when the sound was in contact with the lining membrane. The general health was very indifferent, and there was great nervous prostration with despondency. The bowels were constipated, and there was polyuria.

General treatment consisted in the administration of an enema every second day, and a pill containing 2½ grs. valerianate of zinc and 2 grs. extract of conium was ordered to be taken forenoon and afternoon. Local treatment: I dilated the internal os twice a week, and applied to the whole area of the canal a saturated solution of iodine with carbolic acid, and a tampon soaked in glycerine of alum and boracic acid was introduced into the vagina and placed in contact with the uterus. This treatment was continued for four months, at the end of which time the hyperplasia was reduced and the metritis removed, when the menses were discharged free from clots and without pain. She shortly afterwards became pregnant, and was delivered at the full time of a well-nourished child. She called on me only a few days ago to report herself as being in perfect health.

This is, perhaps, the most perfect example of dysmenorrhœa accompanied by clotted discharge and due to endometritis that I have seen, though I hold it is only typical of the effect of an inflamed surface upon blood which is in contact with it. On looking at the specimens it will be observed that their short retention in the uterine cavity has

resulted in their taking on a kind of fibrous formation, due to their having become to a certain extent partially organised. I have no doubt that such cases are frequently confounded with membranous dysmenorrhœa, whereas the casts, or rather masks, which are pathognomonic of this disorder, are the results of a more intense form of dysmenorrhœa than that which produces these coagula. If the inflammation is still more intense, plastic lymph is effused into the superficial layer of the membrane, whose vitality has been destroyed by the same agency, and it is shed *en masse*, and expelled as a complete mask of the cavity, the exfoliated cellular structure having been rendered coherent by its being impregnated with the effused lymph, just as we have a slough thrown off when inflammation attacks the granulations of a healing sore. Again in croupous dysmenorrhœa we have this plastic lymph partly organised, and retaining the contour of the cavity when it has been deposited on the surface of the lining membrane.

It is worthy of observation that the more severe the inflammatory symptoms are, and the more intense the dysmenorrhœa is, the discharge as a rule is in a like proportion scantier, and in the ratio of the pain losing in severity the discharge becomes more copious. This is only to be expected when we take into account that the more acute the inflammation, the farther removed it becomes from healthy structure, and consequently exerts its catalytic power more in producing coagulation, and therefore lessens the tendency of the ruptured vessels to bleed. Take a case of slight congestion of the integument as an example illustrating what I mean to demonstrate; the congestion produced by cupping, say; when an incision is made into it what is the result? a copious flow of blood of course. How different is the effect when an intensely inflamed part of the integument is incised, a carbuncle for example. Here effusion has taken place into the cellular tissue consequent upon the occlusion of the capillaries by clot having formed within them, this being due to the blood having been acted upon by the irritant destroying either

partially or completely the vitality of their walls. We will have in this instance comparatively little hæmorrhage, and, moreover, we will be able to note how much more rapidly the effused blood coagulates than when it flows from a wound when the congestion is less intense, thus accounting for the more rapid cessation of the bleeding in the one case than in the other. It is not unnatural to conclude then that the same argument holds good in uterine hæmorrhages. But it may be asked, how does it happen that the cast in fibrous dysmenorrhœa is firm and coherent, while a slough is soft and flabby? Well, in the one example, that of the cast, it has not been exposed to the influences of decomposition, the uterine canal being aseptic, and in consequence it is not at once deprived of all its vitality, and therefore becomes slightly organised by remaining in contact with vital tissue; whereas in the slough, before it is actually dead, it becomes a prey to the germs of putrefaction which surround it, and thus speedily breaks down by decomposition. We perceive then that, when the inflammation is less intense, we have less tendency to occlusion of the uterine capillaries than when it is severe, and consequently there is a freer discharge with which there is comparatively little pain, but as a result of the continued hyperæmia a hyperplasic and flabby condition of the uterus takes place, and this want of tonicity of the walls favours the liability to the occurrence of flexions. When these become established, however, although they may not actually act mechanically in obstructing the flow, a much more painful array of symptoms is to be dreaded, for although the calibre of the canal at the seat of flexion may not be interfered with sufficiently to obstruct the exit of the discharge, yet, in consequence of the bend interfering with the venous return flow, the body and fundus take on a more decided inflammatory condition and so become much more sensitive than before, this being due to the walls becoming more rigid and the nerve filaments being more compressed. When the menstrual period comes round, therefore, this condition is still further aggravated by any contractile effort, being accompanied by

increased pressure for the time being, and consequently by more intense suffering. The transition from flaccidity to rigidity of the uterine walls in flexions is of course gradual, and it is not necessary that rigidity should result at all, for if the flexion is recognised at an early stage a vaginal pessary will prove of immense service and a speedy cure will result if the metritis is treated *pari passu*. If, however, the latter condition has been established, it would be highly dangerous to force the uterus into its normal position, and retain it there, without first taking measures to reduce the inflammatory condition of the walls by tampons and intra-uterine medication. Let me give details of a case in point, which I copy from my notes. Miss H. consulted me on April 28th last. She was suffering from acute retroflexion of the uterus and was wearing a Hodge's pessary, which she said had never given her any relief, but on the contrary aggravated her symptoms. A year and a half ago she had sustained a severe fall while playing lawn tennis, and from that date her sufferings began. She had been under treatment for some time by the family attendant without deriving any benefit. She was then taken by him to a specialist, who took her in charge and treated her in the orthodox way by means of pessaries and rest. This was continued for five months without the slightest benefit resulting, when he said he could do no more for her, and advised her to go to Edinburgh and consult an eminent gynæcologist there. The patient naturally shrank from the idea of leaving her home, and I was asked to see her. As has been stated, there was retroflexion, but arising from this there was regularly recurring most severe dysmenorrhœa and menorrhagia, which so prostrated the poor girl that the intervals between the menses were simply occupied in preparing for the next epoch, when the strength was again completely exhausted. This unsatisfactory state of matters had gone on for months, and the patient and her friends began to lose all hope of her ever being well again. She was unable to stand or walk without severe pain, and in every sense of the word she was an invalid.

On making a vaginal examination, I found the os quite patent, and exuding from it an acrid purulent discharge which had given rise to vaginitis, so much so that the mere passing of the finger along the vagina caused intense pain. The uterus, but especially the fundus, was likewise acutely sensitive to the touch. Metritis, therefore, accompanied the malposition, and this was evidently the cause of the dysmenorrhœa and menorrhagia. The metritis, on the other hand, was due to the disturbance of the circulation consequent upon the flexion. I did not attempt to pass the sound, but contented myself with gently supporting the fundus by means of a medicated tampon, which I renewed twice a week, the object being to deplete the congested tissues and constringe the uterine walls and those of the vagina. Gradually but surely relief ensued, so much so that at the end of fourteen days I was able to pass the applicator charged with carbolised iodine into the uterine canal, and thus attack the endometritis directly, which aided very much the treatment directed to the inflammation of the parenchyma. The result was that the discharge lost its purulent character in a few weeks, and the vaginitis rapidly disappeared. A great point of advantage was thus gained, as the displaced and otherwise diseased organ could now be treated without entailing much suffering, whereas, until the excessive sensitiveness of the vagina had been removed, the local applications produced great pain. The tampon was applied bi-weekly for two months, and the endometrium was swabbed every eight or ten days with carbolised iodine. At the end of this time the dysmenorrhœa and menorrhagia were very much abated; the backache, which has been such a marked feature in the disease, was almost gone; and the patient, instead of being low-spirited and depressed, became bright and cheerful. For two months more I saw her once a week, by the end of which time all symptoms of disease had disappeared, and the position of the womb was normal. I may add that up till quite recently the patient has been under my observation once a month, but

she is now so well that she proposes taking a tour through the States and Canada.

It will be seen, then, that I do not hold in much favour the views so much advocated by some, that flexions act mechanically in producing dysmenorrhœa; however, I would not like to deny that there may be *some* truth in such a theory, but it is so far removed from the main cause that prominence ought not to be given to it, for if this is done our treatment is sure to be productive of but little relief at the best. I have frequently seen cases of severe dysmenorrhœa when the direction of the canal was normal and quite patulous, so much so that the sound passed with the greatest ease. In these cases, however, metritis was present, and when this was removed the menstruation became painless, and the general health rapidly improved. Again, I have not unfrequently seen cases of traumatic retroflexion from a fall result in severe metrorrhagia without the slightest pain accompanying it, and certainly where no evidence of obstruction was present. Here you have an unloading of the overcharged veins, the hæmorrhage keeping down inflammatory action by not permitting congestion to supervene. In these cases, as soon as the malposition was rectified, and the uterus retained in its normal position, the hæmorrhage ceased, proving, I think conclusively, that it was the interference with the venous return flow that caused the overstrain upon these vessels. But, on the other hand, when the flexion takes place gradually in a uterus which was not healthy to begin with, the congestion becomes gradually intensified, and the blood coagulates as it is effused, so that which otherwise might be a copious flow to a great extent is checked, though really its duration is not unfrequently prolonged as a consequence of the displacement.

The more I see of dysmenorrhœa, the more convinced do I become that the mechanical obstruction theory is weak. I cannot view stenosis, even when it exists, as a cause *per se* of this disorder. If the os is so far patent as to permit the passage of a very fine uterine probe, and the endometrium is

healthy, it is quite possible for the discharge to escape without pain. Yet I can understand, if the discharge is profuse, it may flow from the lining membrane in a greater amount than it can be evacuated, and so give rise to painful uterine spasm; but if this contraction were the sole cause of the pain, we would have the pain continuing throughout the whole period of the flow, instead of which it generally subsides after the first or second day, or, in other words, when the depletion has relieved the congestion of the organ. A stenotic os, then, may, and does frequently, become a factor in producing an irritable and sensitive condition of the parts, and will eventually lead to inflammation. If this narrowing of the outlet was really the sole cause of the pain in these cases, we would be certain of a cure were it dilated or incised, but how frequently do these operations fail to give relief if measures are not likewise taken to improve the health of the organ itself. It very frequently transpires that a woman with stenosis suffers more at one time than another, and this although the calibre of the canal remains *in statu quo*, showing, I hold, that the narrow aperture does not explain the *casus morbi*. Constipation is a notable accessory to the production of the pain, however, and this because a loaded colon and rectum interfere not only with the pelvic circulation, but also with the tone of the system at large, inducing an overcharged state of the veins, and therefore a more copious discharge, also reducing the general tone, which develops a neuralgic condition. If this sluggish condition of the bowels is removed, in many instances the dysmenorrhœa will cease simply because the quantity of the discharge is reduced, and the general tone improved. But it is not always an easy matter to get hold of such cases in their initial stages, on account of the delicacy that naturally exists in young girls to submit to any kind of treatment for dysmenorrhœa. So much, indeed, is this the case that it has come to be looked upon as a natural consequence of menstruation, and so it is allowed to develop till it is beyond the reach of simple remedies. When, therefore, this state of matters is allowed to

continue for a lengthened period, the organ, in consequence of repeated spasmodic efforts and continuous loss of tone, becomes the seat of disease, so that we have not only a hypersensitive, but an inflamed uterus to deal with. We then have clotted discharge, and such a prolongation of the period that it merits the title of menorrhagia. It is because of this free discharge, however, that the pain ceases when the flow begins to be copious, from the fact which I have so often pointed out, that the overloaded vessels relieve themselves for the time being, and the congestion is in abeyance, nature acting as her own physician.

It will thus be perceived that I look upon a hypersensitive condition of the uterine walls, due to an inflammatory condition, as the essential cause of the majority of cases of dysmenorrhœa, and this for the following reasons:—1. A congested uterus being already hyperæmic has this condition aggravated at each molimen. 2. Because every contraction of its walls is accompanied by intense pain in consequence of their congested condition. 3. Because the inflamed tissue exerts the influence of an irritant upon the constituents of the blood, causing it to separate into clot and liquor sanguinis, the clot necessitating uterine contractions for its expulsion.

We, however, meet with many other conditions besides those mentioned which tend to set up inflammatory action in the womb, and consequent dysmenorrhœa, and perhaps one of the most common is an elongated cervix. Here we may have no narrowing of the canal, and yet it is a frequent source of mischief, and this is proved by the fact that, although the dysmenorrhœa is removed by judicious treatment, it will tend to return again, and this almost invariably, if we do not take the precaution to remove the redundant tissue. So much am I convinced of this that I have for some time refused to have anything at all to do with cases of dysmenorrhœa where this deformity exists, without I first get permission to remove what is abnormally developed, and frequently this has been all the treatment required.

Much, however, as I adhere to the belief that an inflamed condition of the uterine tissue is the chief factor in producing this painful affection, I do not for a moment wish it to be thought that I believe this accounts for every case; but as during the past five years close upon 1,000 cases of this disorder have been treated by me, and as I have found that most of these have been the subjects of endometritis, and it was only when this was removed that the painful symptoms disappeared, it cannot be a matter of surprise that my convictions are what I have expressed.

The cause of metritis may, and most assuredly does, proceed from a variety of sources. It may, and frequently does, arise from an atonic state of the system at large, inducing flaccidity of the uterine walls, and, moreover, interfering with the circulation in the uterus by diminishing the heart's power. If atony of the heart exists, then the uterus, from its anatomical relation to the neighbouring parts, is the first or one of the first organs to suffer, so that in the treatment of all uterine disorders it becomes of necessity a part of our plan of action to take means to restore the general health simultaneously with our efforts to relieve the local symptoms. A first duty, then, is to take particular note of the condition of the bowels, for if these be inactive we have present a common source of anæmia and bad health, in *young* women especially. Not only does a sluggish action of the colon act mechanically by interfering with the circulation in the pelvis, but in not a few instances by actually displacing the uterus. It also permits of a constant absorption of fœtid matter into the blood which destroys the health and even the vitality of the red corpuscles, thus reducing their number and quality. By this not only is the blood deteriorated, but through it the nervous system is injured, and the whole of the functions of the organism thrown out of gear. I do not think I need remind you, gentlemen, how almost invariably this condition of things is prevalent among delicate young ladies, and how dire are the consequences; but I must confess I am surprised to observe how uniformly this important point is overlooked

by medical men, and to what a small degree it is recognised as a *casus morbi.* It would seem as if they were satisfied if they order a dose of laxative medicine occasionally. But, gentlemen, this will not suffice. The bowel must be emptied thoroughly every day, or second day at least, and this can only be accomplished by a systematic and prolonged use of the enema, together with the administration of a tonic which will tend to restore the functions of the atonic muscular fibres of the intestine. It were time to a great extent wasted in the treatment of uterine disease if we neglect this important feature of the patient's condition. But to return to the subject more immediately under discussion, other ascribed causes of dysmenorrhœa must be referred to.

1. It may arise in conjunction with stenosis, but, as I have before observed, the stenosis cannot be the sole cause, or why does the pain cease when the flow has become thoroughly established? Or why do some women suffer while others do not, the outlet being of equal calibre in the various cases? Or, again, why do some suffer at one time and not at another?

2. Dysmenorrhœa may accompany a neuralgic condition of the uterine walls, and frequently does so, for well we know that a neuralgic woman always suffers most at the catamenia, not only in the pelvic organs, but elsewhere, and it is quite natural that the activity of the uterus at that time will render it doubly liable to neuralgia then.

3. Dysmenorrhœa has been said to be due to spasm of the uterus, and has been compared to the spasm which produces asthma; and by way of argument, Dr. Matthews Duncan says: 'Asthma is cured by a copious secretion of the mucous membrane, just as dysmenorrhœa is generally relieved when the menses flow freely.' Now, I hold that the very reverse is the case, for it is only when the spasm in asthma ceases somewhat that the mucous membrane is *able* to secrete mucus to any extent. When the spasm is severe, the nerve centres which control the mucous secretion by reflex action are paralysed temporarily, and it is only when the

irritating effect of the spasm subsides that they are able to act, when the modified irritation which remains stimulates them to free action, when a copious flow of mucus results, just as when a severe inflammation of the Schneiderian membrane occurs no mucus is secreted, but when this subsides the more intense irritant ceases to act so powerfully on the ganglionic centres when their activity is restored and afterwards stimulated by the moderate degree of irritation which the less congested condition of the mucous membrane conveys through their afferent filaments. So that the relief in asthma when mucus is secreted freely is *not* 'post hoc propter hoc,' whereas the relief obtained in dysmenorrhœa when the flow is established *is* 'post hoc propter hoc.'

4. The obstruction theory has had many advocates, amongst whom is numbered Dr. Barnes and the lamented Dr. Marion Sims, but, unwilling as I am to differ from these veterans in the science of gynæcology, I must confess that I fail to see how fluid blood should be less able to escape without pain than the catarrhal discharge which is so copiously excreted in the intercatamenial period, nor can I understand why the pain ceases after the menstrual flow has been thoroughly established.

But, gentlemen, I came here to give my views on this important subject, and not to criticise those of others, and as I have expounded these as explicitly as the time at my disposal permits, I with deference leave them for your consideration.

Dr. AVELING, while admitting that there were many other causes of dysmenorrhœa than those of mechanical origin, thought it a mistake to think that the menstrual fluid could always pass through a small opening in the cervical canal, for the discharge was often accompanied by fragments of membrane and clots, which might cause obstruction even if there were no atresia. Also it was an error to conclude that, because a sound could be easily passed in uterine displacements, no retention of fluid could take place. It would be just as absurd to maintain that no retention of

urine could exist because a catheter could be passed along the urethra, and yet we know that displacements of this canal will obstruct the flow of urine from the bladder.

Dr. CHALMERS remarked that he could trace back the fundamental principles, physiological and pathological, presented by Dr. Bell, as exhibited in the process of menstruation and its derangement, to the teachings of an illustrious surgeon, under whom both had the pleasure of sitting as pupils. This scheme of inflammation, congestion, and coagulation looked very well on paper, but, on coming into continued observation of the living body, proved inadequate to explain all the varied phenomena of the functions of the uterus in health and disease.

Dr. BARNES wished to express the sincere pleasure which Dr. Bell's paper had given him. Of course, there was much in it which challenged inquiry. And this it would undoubtedly have. It was so full of suggestive matter that time was required for its study. Dr. Barnes claimed for himself that he was by no means committed to one condition as the cause of dysmenorrhœa. There were several causes, but he was convinced that obstruction to the ready escape of the menstrual flow caused by stenosis of the os externum was one of the most frequent. The maxim 'curatio ostendit morbum' applied here with remarkable force. Dilation of the os externum by incision was in countless cases followed by cure. It had two great advantages over dilatation by bougies. First, an operation neither severe nor dangerous was commonly enough, whereas dilatation by bougies might have to be repeated an indefinite number of times; secondly, the immediate effect by relieving engorgement of the tissues was beneficial.

Dr. HEYWOOD SMITH wished to ask Dr. Bell why, taking the view he did with regard to congestive dysmenorrhœa, he had not recommended the use of leeches or puncturing the cervix.

Dr. BANTOCK was quite ready to accept Dr. Bell's account of the condition of the uterus and its mucous membrane during menstruation, and to assent to the doctrine that hyperæmia was a very frequent cause of dysmenorrhœa,

but he could not agree with him that flexion and constriction were of no importance. He thought that extended experience would convince any man who pinned his faith to any one cause that he was in error. He held strongly to the view, as the result of extensive observation, that anteflexion was in itself a frequent cause, whether associated or not with constriction of the canal. Otherwise how was the beneficial effect of the stem to be explained? Then the cases were numerous in which the dysmenorrhœa was due to constriction of the internal os. These were cured with great certainty by division of the constriction. In the early stage of these the bougies often effected the object in view. In many cases the flexion was undoubtedly the starting-point of the subsequent hyperæmia and consequent constriction, and, this being so, it necessarily called for treatment.

Mr. LAWSON TAIT asked Dr. Bell on what evidence he made the statement that an ovum was matured in a woman once a month.

Dr. EDIS, without expressing any opinion as to Dr. Bell's pathology of dysmenorrhœa, quite agreed with him as to the importance of studying carefully the *condition* of the uterus in these cases as well as the *position*. Anteflexion of the uterus might be well marked and yet no evidence of suffering exist so long as congestion or inflammation were absent. Numerous instances of dysmenorrhœa occurred where the position of the uterus was perfectly normal, but its condition was anything but healthy. This was a point too often overlooked; the mechanical theory did not explain all cases. In the treatment of patients where the uterus performed its functions painfully, our first effort should be to improve the general health in every possible way. This alone would often prove sufficient. Where, however, congestion was conjoined with flexion, it was often found that replacement of the organ and maintaining it in a normal position tended to relieve the congestion as well, and so cure the patient.

Dr. BELL replied.

The meeting then adjourned.

BRITISH GYNÆCOLOGY, PAST AND PRESENT.

INTRODUCTORY TO A COURSE OF LECTURES DELIVERED AT THE CHELSEA HOSPITAL FOR WOMEN.

By J. H. AVELING, M.D.

SENIOR PHYSICIAN TO THE HOSPITAL, VICE-PRESIDENT OF THE BRITISH GYNÆCOLOGICAL SOCIETY.

GENTLEMEN,—I have, in the first place, the honour of welcoming you within the walls of this hospital. In doing so I am joined by my colleagues in wishing to make this welcome as hearty as possible. Our object in delivering these lectures is to discharge a duty which we think devolves on all those who have exceptional advantages in gaining experience, namely, that of transmitting to others the experience they have reaped—neither, from undue modesty, hiding their light under a bushel, nor, from niggardliness, wrapping their talent in a napkin.

On your part we know that it must be both your interest and inclination to make yourselves masters of the subjects upon which we propose to treat. It must be your interest, inasmuch as the successful management of the diseases of women is the key to general practice, and forms a large proportion of your work. Women, as you well know, enjoy and always find time to gossip with one another, and their complaints are as favourite a topic of conversation with them as dress or servants. Woe be to the unhappy practitioner who has failed in his treatment of their corporeal troubles; his condemnation will be widely heard. On the other hand, he who has been successful in his work will have the trumpet of

his fame sounded with exaggerated force to the uttermost ends of the earth.

But it will not only be your interest but your inclination to make yourselves successful gynæcologists, for, besides the pleasure of doing work of which you feel yourselves masters, no man can have a more satisfactory occupation than that of relieving the miseries and assuring the comfort of the sex to whom we are all indebted for our greatest happiness and our very existence.

In approaching the history of this subject, some mention ought perhaps to be made of John Gadesden, who in the fourteenth century was called by the public 'the ladies' doctor.' Although the first English physician employed by Royalty, he was a most contemptible charlatan, and there is nothing to be found in his works entitling him to consideration as a gynæcologist.

The first dawn of gynæcology in this country is to be found in a beautiful vellum manuscript of 234 pages, on 'The Maladies and Syknesses of Women,' now preserved in the British Museum, being No. 2463 of the Sloan MSS.

It was probably written about the end of the fifteenth century. The author of it is unknown, but, whoever he was, he must have been very well acquainted with the writings of Rogerius of Parma, whose book was first printed in 1490. In some instances the text of the MS. is a verbatim translation from this author, and the arrangement of the chapters is almost exactly similar to that adopted by Rogerius. I thought this MS. of so much importance, historically, that I had it copied, and am now able to give you an analysis of its contents.

The style and vocabulary of its author may be gathered from the following excerpt from his preface: 'For as moche as ther ben manye women that hauen many diuers maladies and sekenesses nyhg to ye deth and thei also ben shamefull to schewen and to tellen her greuances to any wyght: Therefore I schal sumdele wright to herre maladies remedye. Praying to God ful of grace to sende me grace truly to write to ye plesaunce of God and to all womannes helpyng ffor

charite ayeth this that every man schuld trauaile for helpyng of his brotheryn and his susteryn after ye grace of God that he hathe underfongyn.'

The MS. is divided into twenty sections, which treat of the following subjects: 1, menorrhagia; 2, amenorrhœa; 3, hysteria; 4 to 11, displacements, wind, dropsy, soreness, abscess, aching, wounds, and cancer of the womb; 12, diagnosis of pregnancy; 13, childbirth; 14, moles; 15, retained placenta; 16, post-partum hemorrhage; 17, sterility; 18, laceration of the perinæum; 19, urinary disorders; 20, diseases of the breasts.

Not one of these sections deals with natural labour. The one on childbirth only gives instructions for dealing with complications. The reason of this is obvious. At this period cases of natural labour were attended exclusively by midwives, and the doctor was only called in when these women failed to deliver their patients.

As illustrating the condition of gynæcology at this early date the MS. is very valuable. In amenorrhœa the author advises blood-letting. 'Profitable bledyngs,' he says, 'ben att ye veynes of ye gret toon and to be ygarsed on ye leggis bynethe the sparlyner bothe byfore and behynd and to be cupped bynethe ye tetes and also bynethe ye reynes behynde.' He also advises medicated pessaries four or five days before the period is expected, and says they 'schuld be bounde with a threde abouten oon of her thyes lest they were drawe all in to ye moder.' The fear of suppositories being drawn in was common at this time, for Matthew de Gradi tells us of a girl who vomited a suppository shortly after it was administered, also of another breaking the thread which bound it to her thigh, and still another which had been bound to her thigh with four threads.

For menorrhagia he gives this curious remedy: 'Take a quyk turtille (live pigeon) and brenne hyre al quyk with the fetheren, and take an ℥j. of dragon's blode and brenne hem therwith in an erthyn potte al to poudre and lete her usen that poudre in sauce, in potage and in drynk.' If this does not

answer, he says, 'sette blode boxes on hir tetes with fyre and but these sufficen God is medecyn, and no man but he.'

In hysteria the treatment by compression is mentioned. He says patients suffering from it 'witholden her wombe and clippen it hard togedre with her hondes and maken other men otherwhiles to thryst her wombe togeder.'

He quotes the case of a woman who was delivered of a mole, 'a flesshy lumpe without lyf,' 'by ye wyndyng of two towailes aboute hir myddell and twoo stikkis. The oon was wounden on ye oone syde off ye woman and ye other wounde on ye other syde of hyr till ye wombe of hyr was made right small.'

Perhaps the most interesting part of this MS. is that which refers to laceration of the perinæum, to prevent which he says: 'For to kepe women from this myschef in that tyme that they traveyllen of childe lete make a rounde thyng of the shappe of an eye (egg) of small lynnen clothe and putte it in her fundement and euerich tyme of chylde and everych such tyme lete thrust that balle in her fundement and that shall sauen the skyn hole from brekyng.' Of the cause and treatment of lacerated perinæum the author says: 'Divers tymes it happith of diuers women a mischeuous greuaunce in trauaillinge of chylde for defaute of good mydwifes and that greuaunce kepen priue and it nedith for to be holpen. To summe women happith this greuaunce that the peritoneum brekith that there is but oon issue for both voydaunces and of these women ofte tymes comith out ye matrice for ye way is made so large in hir trauaylyng.' The author's treatment, when laceration has taken place, is as follows: 'Sewe ye breech of ye peritoneum in thre places or foure with a double silken threde with a quarell nedell, thanne putt a lynnen cloute in to ye membre after ye quantite of ye membre and ley ye pacient in hir bedde up right so that her fete lye heyher than her hedde and lete hyr lyen so ix. dayes and so without remevyng fro thens do her nedys. And after ix. dayes ben passed make hyr arise and mesurabelich let her kepe her selfe fro trauaylle or besynesse.'

Contenting ourselves with these few illustrative abstracts, we must leave this interesting MS. and pass on to the middle of the seventeenth century, when we encounter a gigantic genius, William Harvey, the benefactor of our race and the 'chiefest ornament' of our profession. Nature was his love. He devoted his whole life to wooing her and winning from her her secrets. No fashion nor passion could turn from her his ardent gaze. To his broad mind nothing existing was small or insignificant. He did not refuse to investigate a subject because it happened to be despised by others, and thus it was that he became the first Englishman to write a book on midwifery, an art at that time looked down upon by the profession and considered far beneath their notice. To Harvey gynæcology also owes much; for his superior knowledge of anatomy enabled him to propose modes of treatment far in advance of his contemporaries. His bold and original mind, freed from the traditional bonds of Hippocrates and Galen, took a fresh and accurate view of uterine disorders and a direct and practical method of treating them.

It is necessary that I should here call your attention to a very important point in the history of gynæcology and one which our most excellent resident medical officer, Dr. Harper, is assisting me in endeavouring to decide, viz. whether in the spurious Hippocratic writings there exists any evidence of the adoption of intra-uterine treatment. The solution of this question must for the present be left in doubt, but one thing is certain, that neither Harvey's master, Fabricius, nor his contemporaneous countryman, Dr. James Primrose, knew of any such mode of treatment, for they both distinctly state that intra-uterine treatment is impossible. Now, in contrast with this belief, let me read you a passage from Harvey's book on 'Generation.' He says: 'The uterine orifice is alike blocked up in all other animals as it is in women; whose womb we have known so closed sometimes, that their courses, purgations after delivery, and other humours have, for want of free disburdening, excited most terrible hysterical affections, insomuch that I have been fain *to invent an instru-*

ment proper to this inconvenience, whereby the orifice of the womb being opened, the imprisoned superfluities might be released and the recited casualties subdued; as also that *injections* might find a reception in the cavity of the womb, by which I have sometimes cured the internal ulcers of the matrix and also barrenness itself.' This remarkable passage displays the originality and intrepidity of its author. With us the dilatation of the cervix uteri and the employment of intra-uterine injections are, comparatively speaking, recent methods of gynæcological practice. With Harvey they were ordinary modes of treatment, and he relates a case of the wife of a doctor of divinity whom he cured by this method, after many physicians, who had used the speculum alone, had failed.

If any of you should at any time feel inclined to repine and complain that your talents are not recognised as speedily as you think they ought to be, think for one moment of Harvey. His contemporaries looked upon him as cracked, and thought very little of his practice. The College of Physicians of London, which to this day basks in the radiance of his genius and enjoys the scientific renown and material wealth which he bestowed upon its members, failed to honour him while he lived. He was never president of the College, and, to their undying disgrace, the honour was not even offered him until he had one foot in the grave and was too old to accept it.

The first British work on gynæcology which appeared in print was written by Dr. James Primrose, a Scotsman by extraction, who studied in Paris, graduated at Oxford, and practised at Hull. His work, 'De Mulierum Morbis,' which is written in Latin, was published at Rotterdam in 1665. He was a man of great learning, research, and industry, but of no originality. He opposed Harvey's doctrine of the circulation, and employed himself more in recording what was already known than in endeavouring to extend and aid the progress of scientific knowledge. His work is divided into five books. The first is on menstruation and its disorders; the second and third are on diseases of the uterus; the fourth is on difficult parturition and disorders of the pregnant and

puerperal conditions; and the fifth is on mammary disorders. It is a quarto volume of 396 pages, and the small attention which obstetrics obtained at that period may be gathered from the fact that only sixteen pages are devoted to the consideration of difficult labour; natural labour is ignored altogether.

For a hundred years after Primrose the writers on gynæcology were very few, and their works of no practical value. The most popular of them was the 'Female Physician,' by Mowbray. He was a pretentious and ignorant practitioner, as may be gathered from the following few lines from the preface to his book: 'These healing and obstetricious arts are so much improved and advanced that they now seem to be arrived at their very height of perfection. So that there is almost not one disease which can affect the woman from her birth to her death, in child, maiden, wife, or widowhood, whose essence, species, differences, causes, signs, and prognosticks we have not sufficiently cleared up.' He wrote from his 'house in New Bond Street, over against Benn's Coffee House, near Hanover Square,' in 1724.

Dr. Henry Manning wrote 'A Treatise on Female Diseases' in 1771. His book has, he says, 'at least this circumstance in its favour, that it is the only work which exhibits a complete system of the diseases of women.' These diseases, he adds, 'depend principally on an excess or diminution of the menstrual discharge.' How 'complete' his system was may be gathered from the fact that all the diseases of women, not due to pregnancy, which he mentions, were disorders of menstruation, fluor albus, hysteric passion, furor uterinus, inflammation, scirrhous tumours, abscesses, ulcers, prolapsus and inversion of the uterus, and diseases of the ovaria and Fallopian tubes, which he disposes of in eighteen lines. In speaking of scirrhous tumours, he says, 'It is sometimes necessary, for further satisfaction, to introduce the finger through the vagina to the uterus if possible, and examine the state of the organ.' Digital examination was seldom employed at this period, practitioners contenting themselves with

treating symptoms which they mistook for the disease itself.

It was not until the beginning of the present century that gynæcology began to be studied in an independent and rational manner. Hitherto gynæcologists remained bound by the traditions of the older writers, through which no one except Harvey seemed to have had the power to break. At length came new light, and one of the first to bestow it was Sir Charles Mansfield Clarke, who, in his 'Observations on those Diseases of Females attended by Discharges,' gave new life to British gynæcology. He had two objects in view: to make some arrangement of the sexual diseases of females, and to point out the dangerous consequences of treating symptoms instead of diseases. These diseases, he adds, are perhaps less generally known and understood by practitioners than any other complaints to which the human body is subject. The great work which Sir Charles M. Clarke did was to show that fluor albus was not a disease but a symptom, and that the various discharges called by that name were the signs of different diseases, each requiring special treatment.

There appeared also at the beginning of the present century a remarkable book on 'Diseases of the Uterus,' by Dr. G. Rees. He speaks of the 'insufficiency of our present information, and the obscurity which has hitherto enveloped the subject.' He hopes to persuade the practitioner to afford *manual* assistance when the opportunity presents. In this sentence we see the dawn of operative gynæcology in this country. Up to this time even digital examination is rarely mentioned, and more seldom recommended. Dr. Rees popularised the use of intra-uterine injections, which had been practised by Harvey and Dr. R. Wallace Johnson, the latter employing it, and giving a drawing of his mode of performing the operation in his 'System of Midwifery,' published in 1769. Dr. Rees says: 'The manner of injecting the uterus ought to be properly understood by the person who attempts it, and should be done with a great deal of delicacy and caution, for the parts are sometimes, from inflammation and disease, so

exquisitely sensible that all rough management will be insupportable, and will not fail to augment the sufferings of the patient. That the applications to the cavity of the uterus itself are useful and necessary is evinced by the present case (Dr. Johnson's), and I do not see how a disease can be cured by local remedies if they do not come into immediate contact with the seat of the disease.' The work of Dr. Rees is also interesting, inasmuch as in it is to be found the first mention of an air-pessary. There has been much discussion as to the authorship of this appliance. It was first used in cases of prolapsus, and is thus described by Dr. Rees: 'The late ingenious Dr. Aitkin, of Edinburgh, has lately invented and recommended an air-pessary, which he considers as possessing in a superior degree the properties so requisite in this case—smoothness, lightness, and compressibility. It is formed of a small bladder or bag, soft and air-tight, with a valve at the orifice. It is introduced and then duly inflated by the patient by a long flexible tube, which is immediately retired. This instrument, while it is exceedingly light, fully occupies the vagina and supports perfectly the uterus. When it is wished to retire it, the valve is forced and immediately it collapses.'

In dilating the womb Dr. Rees advises the use of the finger, and says all instruments are undoubtedly improper, as the exact force cannot be estimated, and inflammation is liable to be brought on by their use. In dilating the womb to remove a mole, he says, 'possibly it will only be after several efforts that we shall be able so far to dilate the mouth of the womb as to admit the finger'—a remark with which we must all agree. He makes no mention of the method of dilating the womb by the expansion of gentian root, elder pith, and sponge, all of which were used and recommended by James Cooke in his 'Marrow of Chirurgery,' published in 1685. Of course it would be impossible in the time during which you now honour me with your attention to do more than sketch in very bald and imperfect outline the history of British gynæcology. I must endeavour, therefore, by

a few bold touches here and there, and a few characteristic illustrations, to give you some idea of the large subject with which I am dealing.

Hitherto we have noticed a steady advance, keeping pace with time, in the science and art of gynæcology as practised by our countrymen during the sixteenth, seventeenth, and eighteenth centuries. At the beginning of the present century, however, gynæcology had declined and retrograded in a most unaccountable manner. The physical examination of the female genital organs was seldom resorted to, and, if recommended, always in an apologetic tone. Intra-uterine medication, practised by Harvey and Johnson, is not mentioned, and, with few exceptions, all disorders and lesions peculiar to women were expected to be cured by the apothecary's shop. Let me illustrate this by referring to the history of the treatment of laceration of the perinæum. You will remember how the writer of the fifteenth-century manuscript, to which I have drawn your attention, recommends the introduction of sutures to bring together the torn surfaces, and advises that the patient be kept quiet after for nine days. From that day to the time of Smellie, who, it will be remembered, wrote in the middle of the eighteenth century, the practice of stitching up the perinæum, when lacerated, was generally advised. Smellie's practice was, 'as soon as possible, to make two, three, or sometimes four deep stitches through the torn vagina and rectum, *the knots being tied in the vagina*, and two more stitches in the perinæum, to assist the reunion of the parts; the stitches must be made very deep.' You will observe that he recommends the knots to be tied in the vagina—a great advance on those who came before him, who only employed perinæal stitches. Now let us pass on a few years, and see what was the practice early in this century, and I will quote from no obscure authors. Samuel Merriman, a name which will ever be honoured by gynæcologists, calls laceration of the perinæum 'a very uncomfortable accident. The cure of a lacerated perinæum is very difficult, in some cases impossible. It has sometimes been the practice to bring the edges of

the wound together by suture; but this has seldom, if ever, been attended with good effects; on the contrary, the ligatures have been found to slough away, and the patient has in consequence been left in a worse condition than before. *This mode of practice is therefore discontinued.*' John Burns, whose book on midwifery is a lasting monument to his industry and sagacity, treats a lacerated perinæum by rest, approximation of the thighs, and keeping the bowels open. 'Sutures have also been employed,' he says, 'but they are *never* in the first instance to be resorted to.'

This retrogression was only of temporary duration, as may be seen by referring to Blundell's works. He is, however, a little undecided, for he says: 'A ligature may be inserted into the perinæum now and then, perhaps with advantage. To attempt re-union in these distressing cases is always proper.' After this time the practice of stitching up the perinæum, when lacerated during labour, became the rule; and so little is now thought of the difficulty or the skill required in performing it, that the midwives at Queen Charlotte's Lying-in Hospital are taught and required (I think unwisely) to do the operation.

While on the subject of lacerated perinæum, I should like to call your attention to an operation which has been devised for its cure when the parts have not healed immediately after labour. It illustrates the necessity of attaining a competent knowledge of gynæcological history before publishing and claiming any invention as original. In 1853 Langenbeck proposed a new method of operating for the repair of lacerated perinæums. It consisted of dissecting a tongue-shaped flap from the posterior wall of the vagina, and bringing it forward so as to form the anterior surface of the repaired perinæum. This operation, identical, except in unimportant details, has, to my knowledge, been discovered and published as new by three other gynæcologists: one in Belgium, one in England, and one in America. All seem to have been ignorant of the prior claim of Langenbeck. Life is indeed short, and Art is long, but surely it is a duty incumbent on

every one to take the trouble to read up the history of a subject before proclaiming as new that which is perhaps only new to himself.

In 1829 Gooch published his book 'On some of the most important Diseases peculiar to Women.' The appearance of this work produced a profound impression on medical men, and kept alive the interest in gynæcology which Sir Charles Mansfield Clarke's writings had already awakened. The subjects which Gooch especially wrote about were polypus of the womb and irritable uterus. Gooch's canula for polypus is still well known, and, I fear, used. The term 'irritable uterus' became immensely popular, and soon appeared another work on the subject, 'Observations on the Disorders of Females connected with Uterine Irritation,' by Dr. Addison. But these gynæcologists were, as we now know, wandering in the dark, and the 'irritable uterus,' which they looked upon as the cause of so much pain and constitutional disturbance, was not a disease, but only an assemblage of symptoms, concerning the origin of which they had not the slightest idea. The term was as vague as the old 'fluor albus' which Sir C. Mansfield Clarke had so effectually annihilated. It, however, satisfied the doctor of the day, and doubtless he sometimes relieved his patients by adopting the treatment recommended. At this same time Dr. Marshall Hall published his 'Commentaries, principally on those Diseases of Females which are Constitutional.' He was the last of what may be called the medical gynæcologists, for the treatment of the diseases of women up to this date had been mainly in the hands of physicians. It will be observed, in Dr. Hall's 'Introduction,' that a friendly rivalry existed between him and Dr. Gooch, so we may conclude that gynæcology was becoming popular and lucrative.

We have now arrived at an important epoch in British gynæcology. It was not marked by the appearance of an imposing and pretentious volume, but only by the reading of a short and modestly written paper. This paper, which must always remain a source of pride and shame to our profession, was read before the Royal Medical and Chirurgical Society

of London in 1823, no less a person than John Abernethy being in the chair. Its title was 'Physiological Observations and Experiments,' and it was written by Dr. James Blundell, with the object of improving the surgery of the abdomen. Having made a number of experiments on the rabbit, and observed the toleration of the abdomen in man when wounded by accident or design, he came to the conclusion 'that moderate openings into the human peritonæum will not necessarily, nor even generally, prove fatal from inflammation or otherwise; and, further, that certain viscera, or parts of viscera, not essential to the welfare of our structure, may be removed from the belly, without necessarily, or even generally, producing death.' He therefore proposed the following operations, to be performed only in cases otherwise desperate:

1. A division of both Fallopian tubes, and even the removal of a small piece of them, so as to render them completely impervious, a fit addition, apparently, to the Cæsarean operation, the danger of which it would scarcely increase. This operation would prevent subsequent impregnation.

2. The extirpation of the healthy ovaries. This would probably be found an effectual remedy in the worst cases of dysmenorrhœa, and in bleeding from monthly determination on the inverted womb.

3. The extirpation of the ovarian cyst in scirrhus, combined with dropsy, or in simple dropsy. 'This operation will, I am persuaded,' he says, 'ultimately come into general use, and if the British surgeons will not patronise and perform it, the French and American surgeons will.'

4. The removal of a large circular piece of the cyst in ovarian dropsy when the sack itself cannot be extirpated.

5. The removal of the cancerous womb when the ulceration first makes its appearance.

6. Extirpation of the puerperal uterus when the Cæsarean operation is performed, or when a patient is evidently sinking after rupture of the womb.

7. In rupture of the bladder, lay open the abdomen, tie

the bladder, discharge urine, and wash out the peritonæum thoroughly by the injection of warm water.

There are a few other suggestions of minor importance with which I need not trouble you. Enough has been given you to show how Dr. Blundell, having arrived at certain conclusions by a laborious and careful process of induction, was not afraid to march straight on to the goal to which they inevitably led. His bold and independent spirit was not to be daunted by the fear of unpopularity, or the formidable character of the operations he proposed. He knew quite well, although he was lecturer on physiology and midwifery at the united hospitals of St. Thomas and Guy, he would have to meet the fate of all those who fearlessly leave the beaten path and dare to follow boldly the bent of their genius. He quotes, beneath the title of his paper, from Shakespeare, the passage beginning—

'Thou art a blessed fellow, to think as every man thinks, &c.'

Now let us see how this marvellous paper was received. The Royal Medical and Chirurgical Society of London thought so little of it that they did not think it worth publishing, and it did not appear in their 'Transactions.' The 'Medico-Chirurgical Review' condescended to notice it, but merely with the manner in which a person brushes rubbish on one side. On the subject of Blundell's proposal to extirpate the healthy ovaries, it says, 'We think this proposition borders on the wild and extravagant,' and *à propos* of his advocacy of extirpation of ovarian cysts, the reviewer says, 'In despite of all that has been written respecting this cruel operation, we entirely disbelieve that it has ever been performed with success, nor do we think it ever will.'

So much for the opinions of societies and reviewers; but what a lesson!

Does not a society or a reviewer incur a fearful responsibility when it or he, by active opposition, retards the progress of our art and robs humanity for years of the means by which thousands might have been restored to health and

friends, and relieved from months of painful existence and protracted misery? And what a lesson to individual workers not to be discouraged by opposition even from the highest quarters, but to work on honestly and fearlessly, indifferent to ignorant and captious criticism; caring more for their own self-respect than the praise or blame of others, and always confident that honest work must in the end make for the benefit of our fellow-creatures, whose health and happiness are the aim and end of all our labours.

About fifty years ago gynæcology was revolutionised by the importation of a small metallic cylinder from Paris. It was at first received with great suspicion and disfavour, but its use was so unmistakable that in spite of angry denunciation practitioners gradually began to employ it, and in a short time its adoption became general. For its introduction into this country we are especially indebted to William Jones, Balbirnie, and Bennet. The speculum did for gynæcology what the forceps had done for obstetrics. It literally threw light upon a class of diseases about the existence of which there was the grossest ignorance; and simply because no method of diagnosing them existed. Before its employment uterine disease was determined in its character by the kind of discharge which issued from the vagina. Digital examination was rarely ventured upon, and, if adopted, always with the apology that it was undertaken under the direst necessity. It is difficult to understand how so short a time since as fifty years the speculum should have encountered such opposition, for now every practitioner possesses one or more, and they are as various in form and as numerous as the stars in the firmament.

About twenty years after the general adoption of the speculum, gynæcology was still further enriched by the introduction of another diagnostic instrument of the greatest value—the uterine sound. Like the speculum, it was not new, but it was presented to the profession by so great a master, and its practical advantages so distinctly shown, that its adoption became general in a very short space of time.

We owe a great deal to the late Sir James Simpson. I had the honour of his friendship. He had a marvellous memory, was an indefatigable worker and reader, and never forgot what he read. But he did not hold in his broad mental grasp a mass of materials as some do, like an encyclopædia, for he had the rare power of, as it were, digesting his mental diet, and by a happy process of generalisation reproducing, in a practical form, the really valuable part of his knowledge. He also taught us to use dilating tents, which were not new, as has already been shown, and the exploring needle, and to use anæsthetics to assist us in our examinations.

Gynæcology had now emerged from its long period of darkness, and, naturally, began to seek special homes in which its new-born ideas might be nurtured, and their practical outcomings be put to the test of experience. The first institution established in this country for the treatment of the diseases of women was, I believe, the 'Dispensary for Female Patients,' in Leicester Street, which enjoyed the patronage of her Royal Highness the Duchess of York. Dr. Rees, who published 'Observations on Diseases of the Uterus,' was one of the physicians. I have not been able to find out when this charity was established or ceased to exist, but it must have been in operation early in the present century.

The next institution devoted to gynæcology was 'The Free Dispensary and Infirmary for Women, &c.,' in Blenheim Street. William Jones and Dr. Thomson were medical officers to it, and Dr. Robert Lee's and Mr. Guthrie's names are mentioned as having been called in consultation. Jones seems to have been particularly interested in this charity. He calls it the 'Blenheim Street Infirmary for Women,' and indicates its size by speaking of it as a 'Sapling Institution,' which he is anxious to see increased in size and usefulness. In the preface to his 'Practical Observations on Diseases of Women,' published in 1839 and dedicated to Guthrie, he says: 'Until *lately* no attempt has been made in this country to provide a place of *reception* for the treatment of the numerous complaints peculiarly incidental to women, although thousands of

women are annually sacrificed who might be saved did such an establishment exist. Is not every professional man personally interested in the formation of such an institution? Could such an institution exist for any length of time without conferring benefit on him, his family, and the public at large? Would he not daily have an opportunity of obtaining information which could never be acquired in the ordinary routine of private practice? And is the public less interested in the accomplishment of such design? Every man who has a mother, a sister, a wife, a daughter, or any other female relative; every woman whose bosom glows with benevolence, or whose heart can feel for the sufferings of another, is bound, by all that renders life desirable, to assist in the promotion of the charitable design.' This William Jones, who so warmly advocated the establishment of a special hospital for women, lived in Lower Brook Street, and was lecturer on midwifery and the diseases of women and children at the Blenheim Street School of Medicine. As he wrote in 1839 and speaks of this infirmary for women, we can fix the date of its existence, although I have been able to find no record of its foundation or dissolution. It must be observed that this charity was not merely a dispensary for out-patients, for women were also admitted into the building for treatment.

The appeal of William Jones to the profession and the public to found a larger hospital for women was soon answered, for three years after the Hospital for Women in Soho Square was established, and many others soon followed—the Samaritan Free Hospital for Women and Children in 1847, the Chelsea Hospital for Women in 1871, the New Hospital for Women in 1872; not to mention others devoted to the treatment of women and children. In the provinces special hospitals for women have been established, and are to be found in Manchester, Liverpool, Newcastle, Leeds, Sheffield, Bristol, Birmingham, Nottingham, and other towns. In Scotland and Ireland there are not many special hospitals for women, but I believe there is one in Edinburgh and one in Belfast; these countries have, however, in common with the whole United

Kingdom, many excellent lying-in hospitals at which the diseases of women are treated.

It will be asked, For what reason have all these special hospitals been established? Why could not the general hospitals do the work? The answer must be that they *could not* or *would not* do it, and perhaps both of these reasons are true; the latter is, however, most certainly the more potent and correct.

Gynæcology has at the general hospitals been in the unenviable position of resting between two stools—the surgeon and the obstetric physician. The fact is gynæcology advanced too fast for the pace of the hospital authorities. They could not recognise the marvellous development resulting from the introduction of the speculum and sound, and the successful treatment by operation of some of the most fatal and distressing diseases with which women were afflicted. A calculation made not long since proved that the number of beds devoted to women's complaints in the general hospitals amounted to only from three to five per cent. of the whole. This fact alone proves how little practical attention the general hospitals had paid to the increasing demands of gynæcology, or, if they had noticed it, that they *would not* give it the consideration it demanded. This, then, was one cause why special hospitals were instituted. But there was another which still exists, which is a disgrace, and which must be most humiliating and damaging to the obstetric physicians of our general hospitals. Lest I should be accused of partisanship, I will quote the words of these very physicians, for some of them have fully appreciated the position in which they are placed, and have boldly demanded and obtained their independence and operative rights. Any one who wishes to understand the merits of this important question will find it most ably dealt with by Dr. Robert Barnes in the 'American Journal of Obstetrics' for September 1884. He says: 'The obstetric physicians (of this country) occupy a position scarcely better than that of supernumeraries. They have a few beds assigned to them for diseases of women, far less in number

than those assigned to the physicians and surgeons, and ridiculously inadequate to the needs of the poor women suffering from diseases peculiar to the sex, and the cases admitted to these beds are rigorously defined and controlled by the surgeons. The obstetric physician is at liberty to treat surgically a uterine polypus, for example; but he has no monopoly even in this. The surgeons admit into their wards any cases they please, including gynæcological diseases. But cases touching ever so slightly upon the border line between the uterus and the adjoining regions are jealously denied to the obstetric physician.' Dr. Barnes tells us of a curious arrangement made at St. Bartholomew's Hospital with regard to perinæal operations. 'If required for relief of prolapsus uteri, the obstetric physician might do them; if for incontinence of fæces or flatus then the surgeons claim the operation.' No ophthalmologist at a general hospital would submit to any limitation as to the operations he might consider it necessary to perform, nor consent to an arrangement which enabled him to do small operations on the eye but would not allow him to extirpate it. Dr. Godson, who holds the post of assistant physician-accoucheur at St. Bartholomew's Hospital, writes: 'Our surgical colleagues are courteous and considerate to us in the extreme, and find no fault with us for doing such operations as we think fit in the treatment of our patients so long as we abstain from abdominal section and operations for vesico-vaginal or recto-vaginal fistula. But, as the law stands, we have no right to perform the very simplest surgical operation in our ward; and at any moment we might be charged and censured, as Dr. West was, if it were stated that we had removed a small vascular caruncle from the female urethra, or twisted off a small mucous polypus from the cervical canal.'

Take one thing with another, the position of an obstetric physician at a general hospital is not a happy one. Must it not be humiliating for him to have to operate knowing that he has no legal right to do so, and that he is only able to take a knife in his hand because his law-breaking is winked at and tolerated, and his colleagues condescend to treat him with

'extreme consideration'? Must it not be difficult for him to have to teach gynæcology and yet not be permitted to practise it? How else can he gain the practical knowledge which alone can make him an efficient and successful teacher? Must it not be painful to him and disadvantageous to his patient to have her handed over to another for operation when he has been watching her case for some time, has become acquainted with her constitutional peculiarities, knows the effects of remedies upon her, and has become deeply interested in her case? Is it to be wondered at that some of these gentlemen should feel uneasy in their positions when thus bound and degraded? and is it not a marvel that gentlemen can be found to hold appointments under such humiliating conditions?

I have said that this tying of the surgical hands of obstetric physicians is not only humiliating but damaging to them. It robs them of practice, and they know it. The public know quite well who are operators, and who are most successful in different operations. Is it not natural therefore that to these men patients should go when seeking relief? Hence it is that the special hospital men get the cream of operative gynæcological practice, and the obstetric physician is left in the cold. Here is the spring from which wells up the jealous gall wherewith the general hospital obstetrician bespatters the special hospital gynæcologist. Here is the sore, which it is to be hoped will soon become so intolerable that the obstetric physician will cease to be content with the position of a man-midwife, and rise with strength and independence to that noble height in the healing art which is his right, and should be his strenuous endeavour to secure. If he will not do this, a gynæcologist as well as an obstetric physician must be appointed to each general hospital, and the separation between obstetrics and gynæcology, which seems to be more apparent every day, will be hastened.

It is a remarkable sight to see obstetricians banded together, forgetful of the opposition and persecution they once received, watching with jealous eyes the wonderful de-

velopment and strong onward march of gynæcology, ignoring its triumphant progress, and joining with the crowd in aiming at it slanderous imputations, and the poor, petty cry of *specialism*. Why this constant outcry against specialism? A specialist is one who pays special attention to a subject, and who consequently attains superior knowledge of it, and greater skill in dealing with it. I cannot see that anything opprobrious attaches itself to the word specialism, unless special attention be paid to an unworthy object. On the contrary, the noblest work that has been done in the world has been effected by men who had the power of concentrating their attention on one subject. The absurd cry seems to be confined to the members of our own profession. In Art and Science, their votaries are specialists; one poet writes plays, another songs; one painter devotes himself to portraits, another to landscapes; one musician to vocal, another to instrumental, composition. In science it is the same. Other professions are split up into parts. Has not Theology its sects, and Law its divisions? A soldier is not looked down upon because he does not belong to the line, but happens to be an Engineer or Artilleryman. He is all the same a soldier, and is honoured by his brothers in arms and his country whether he fires a cannon or a carbine, whether he walks on his feet or rides on a camel.

What, then, is at the bottom of this intense dislike of medical specialists? A physician or a surgeon may now, it is true, practise his special branch of medicine without incurring the displeasure of the profession. But this was not always so, for those who know the medical history of this country must remember the bitter hatred and petty persecutions in which surgeons and physicians indulged one against another during the seventeenth and eighteenth centuries. The division of medicine into Physic and Surgery is now tolerated, but any further subdivision of these is still looked upon as heresy of the deepest dye, and he who has the temerity to practise one of these forbidden subdivisions is at once looked upon with jealousy and suspicion—with jealousy,

because he is successful; with suspicion, because his success is attributed to quackery instead of superior knowledge. Time will put all this right. No amount of cold-shouldering or ill-disguised persecution can stop specialism. As long as the mind of man remains as limited as it is, no one brain can contain or master the whole art and science of medicine. To attempt to do it would be folly; to profess to have done it would be dishonest. No progress can be made except by long devotion and special attention to one particular subject, and this method of study should not be discouraged, but promoted in every possible way for the honour of our profession and the benefit of mankind.

Opposition is not always an unmixed evil. It is often a healthful stimulant, and so it has proved just now, for, thanks to certain recent snubbings which gynæcologists have received, they have now established for themselves a scientific home and a literary organ. Thanks to opposition, the formation of the British Gynæcological Society has been hastened, and gynæcology has now a separate and independent existence. It had grown too large to live comfortably in the same house with its sisters, Obstetrics and Pediatrics; and the jealousy of one of the sisters had made the old home somewhat unpleasant. With more breathing-room, and freer action, gynæcology will be healthier and grow still more rapidly.

The present state of British gynæcology may therefore be looked upon as eminently satisfactory. We know we are working honestly; we know we are progressing rapidly; we know we are practising successfully; and we are confident that the time must come when our labours will be appreciated, not only by the public, but by the profession at large.

It remains only for me to thank you for your attendance here to-day, and for your kind attention, and to apologise for the imperfect way in which I have handled so large and important a subject.

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REVIEW.

The Principles and Practice of Gynæcology. By THOMAS ADDIS EMMET, M.D., LL.D. Third Edition, pp. 876. (Philadelphia: Henry C. Lea's Son and Co. 1884.)

WHEN so large and important a work as the above reaches its third edition in five years, the duty of the reviewer is not so much to give it a lift or to criticise as to report on the progress of its subject-matter, and to draw attention to the chief points wherein it differs from preceding editions. To compare Dr. Emmet's book with others on the same subject that have emanated from the American press, his carries off the palm for fulness of description and detail of manipulation; and although the points of diagnosis, &c., may not be arranged in so tabular a form as in another well-known work, yet the value of Dr. Emmet's book lies greatly in the elaborate tables with which it is interspersed, and in the number of cases, one hundred and eleven, which illustrate his various methods of treatment. Emmet has done good work in his chapters on prolapsus, prolapse of the posterior vaginal wall, and on 'so-called' laceration of the perinæum, and they should claim the careful attention of all gynæcologists. While 'skeptical' in regard to the perinæal support and to the extent of injury actually sustained when the perinæum is supposed to be lacerated, he nevertheless lays great stress on the restoration to its proper degree of tension of the bulging posterior vaginal wall, and draws attention to a condition wherein, after labour, there exists a crescentic cicatrix just inside the posterior fourchette, in cases where to all appearance there has been no actual tear of the perinæum. His operation for the restora-

tion of this lesion, which is often called rectocele, is neat and effective. The writer, during a visit to New York last year, had the opportunity of seeing Dr. Emmet operate in such a case, and can bear witness to his dexterity and carefulness as an operator and to the successful adaptation of the parts which resulted.

Turning to diseases of the urethra, Dr. Emmet has introduced an operation which he calls buttonholing the urethra, and for which he has devised a special pair of scissors. He resorts to this operation both as a means of exploring the urethra, and also for the cure of prolapse of its mucous membrane. In some cases the mucous membrane is drawn out through the opening which is made about one-third of an inch from the meatus and carefully stitched round it, whereby the opening remains patent until the urethra (or bladder) is restored to its normal condition of health, when it can be easily closed as in ordinary vesico-vaginal fistula. In other cases where there is considerable prolapse of the mucous membrane after the buttonhole has been made, the mucous membrane is drawn out of the wound, while the canal is kept smooth by the introduction of a large sound, and the superfluous tissue cut off, when the opening may be closed by sutures passing through both external urethral wall and the cut edge of the mucous membrane. By this procedure the prolapsus is entirely cured. Altogether the work of Dr. Emmet is one of great value, and this edition has been revised and in part rewritten with great care; and it should, without doubt, be in the hands of all gynæcologists who wish to keep themselves up to the mark in their special science and art.

HEYWOOD SMITH, M.D.

SUMMARY OF GYNÆCOLOGY, INCLUDING OBSTETRICS.

Extirpation of the Uterus.—In the 'Annali di Ostetricia, Ginecologia e Pediatria' for October 1884, Caponotes, of Turin, recapitulates the statistics of Novaro, who has removed the cancerous uterus twenty-one times during the last three years. In one case only did Novaro perform the operation through the abdomen; in the remaining twenty the uterus was removed through the vagina. Ten of the patients died from the operation. Five died later from recurrence of the cancer. Six remain alive, but of these three are again suffering from recurrence of the cancerous growth. Three only at present remain well. The above table of cases does certainly not offer much hope that Freund's operation is likely to become a useful one. It bears out Koeberle's dictum that those who recover have no cancer, and do not need the operation; those who have cancer do not recover.

Subcutaneous Injection of Iron.—Martinelli relates two cases in the 'Annali di Ostetricia, Ginecologia e Pediatria' for October, 1884, which he treated in the following manner. The patients were in a markedly anæmic condition after fungous endometritis. A subcutaneous injection was made daily for twenty-six days with a Pravaz syringe into the gluteal muscles. The solution consisted of citratis ferri 2, aquæ laurocerasi 20. The result was absolutely successful in both cases. Only on one occasion did any painful hardening of the tissues result. This yielded rapidly to the application of an ice-bag, no suppuration taking place.

Analgesia of the Parturient Canal obtained by Cucaine.—In the 'Archives de Tocologie,' February, 1885, Dr. Doleris describes the anæsthetic results he has obtained with cucaine

in labour. He uses a solution of chlorhydrate of cucaine in the proportion of $\frac{4}{100}$ in an ointment. The drug was tested in eight cases. In six cases the result was satisfactory. He found that in primiparæ the pains during the first stage of labour were completely allayed by the application of the ointment to the os and cervix. In others, at the period of expulsion, the pains were so diminished that the patients were no longer in dread of making voluntary expulsive efforts, and only felt pain in the lower part of the abdomen. This occurred to such a degree as to render the period of expulsion practically painless. One result is to considerably shorten the duration of the second stage of labour. If preferred, fifty or sixty drops of the solution may be used instead of the ointment.—FANCOURT BARNES, M.D.

Cucaine in Gynæcology.—Although so much has been written of late on the advantage of cucaine as a local anæsthetic in ophthalmic operations, yet the employment of the drug does not seem to have met with a like success in gynæcological operations. This we can well understand, for, as Dr. B. W. Richardson[1] observes, 'its value seems to have been very much overrated, its application being chiefly confined to operations performed on the eyeball, and then only to those which are superficial. The thin outspread of mucous surface over a negative surface is probably the cause of this special success, and to a large extent indicates the limits of the success.' He sees no reason to suppose that cucaine will be a local anæsthetic to the skin or to mucous membrane resting on a deep cellular basis into which there is rapid absorption of the anæsthetic from the sensitive structure, with quick removal of it by further absorption into the circulation.

Dr. Hughes Bennett,[2] in 1873, published the results of a series of physiological experiments with this drug. Those who are interested in the subject should read Dr. Murrell's article,[3] as also another in the same number,[4] our space preventing us entering into the historical aspect of the subject.

[1] *The Asclepiad*, Jan. 7, 1885, p. 93. [2] *Edin. Med. Journal*, vol. xix. p. 323.
[3] *The London Medical Record*, Dec. 15, 1884, pp. 516-17. [4] Ibid. pp. 512-16.

Mr. Malcolm Morris[1] relates a case of pruritus ani where considerable relief was afforded by painting a twenty per cent. solution over the parts.

Dr. Clement Godson[2] calls attention to its value in the removal of vascular growths from the meatus urinarius.

In cases of vaginismus or extreme sensitiveness of the vaginal outlet, precluding coitus, painting the part over with a strong solution of cucaine has proved of service. In one case where tapping the abdomen was indicated, the hypodermic injection of a ten per cent. solution of cucaine rendered the puncture through the skin painless. Operations upon external hæmorrhoids have also been performed under the influence of cucaine.

The expense of the drug (*2s.* a grain) will prove deterrent to the extensive use of cucaine at present. Many other agents may be employed with probably even better results. Menthol rubbed over the surface will often allay the most troublesome pruritus. Camphor and chloral, in equal parts, forming a liquid, has long been known as a valuable remedy in cases where local anæsthesia of the cutaneous nerves is desired, and has been employed in neuralgia and pruritus. Chloroform, tincture of aconite, ether spray, the application of ice, and numerous similar agents have from time to time been recommended, and have met with a certain measure of success.

Cucaine is at present a fashionable remedy, more especially applicable for minor operations upon the eye, the nose, the throat and larynx. We have yet to learn that the employment of cucaine will be of any practical advantage to the gynæcologist except in a few minor cases, and even these can be dealt with by more efficient and less expensive agents. Weak solutions soon deteriorate, and then produce considerable irritation.—ARTHUR W. EDIS, M.D.

[1] *Brit. Med. Journal*, Jan. 24, 1885, p. 177. [2] Ibid. Jan. 3, 1885, p. 17.

HOSPITAL REPORTS.

THE HOSPITAL FOR WOMEN, SOHO.

Dysmenorrhœa and Sterility with prolapsed cirrhotic ovary. Under the care of Dr. Richard T. Smith.

M. W., aged twenty-six years, married six years, has had no children nor miscarriages. Menstrual history began at fifteen. Catamenia always irregular, varying in interval from six to eight weeks for the first four years, but more recently from fourteen to twenty-one days; the flow as a rule being scanty and often offensive.

She complains of having very acute pain for two days before the flow appears, chiefly in the hypogastrium and left hip. The pain continues but in less severity during the flow, and is relieved by the passing of small clots. There is a feeling 'as if a piece of ice lay in the bowels,' and she is obliged to rest from all work during the periods.

For many weeks all sexual intercourse has been unbearable from the severe tenderness internally.

Vaginal examination revealed a small prolapsed exquisitely sensitive left ovary lying close to the uterus and apparently cirrhosed in texture. The uterus itself was found to be hard, in normal position, of natural shape, with some slight stenosis of the internal os.

The cause of the pathological change in the ovary is rather uncertain. The doctor who first saw her said she had the uterus lying back on the bowel, but no retroflexion existed while under my observation. Soon after marriage she suffered from an irregular, red discharge, with severe pain in the bowels and vomiting, and it is probable some blenorrhagia may have set up ovaritis.

Her general health was apparently good, but so persistent were her appeals for some relief from the dysmenorrhœa and dysenuria that I admitted her three times into the Hospital, and subjected her to all the usual methods of treatment by anodynes, blisters, bromides, &c., directed both to the ovaries and uterus. Within three weeks she had twenty-six leeches applied to the abdomen in the hope of relieving the tenderness, but all to no purpose.

On consultation with my colleagues, opinion was divided as to the expediency of oophorectomy, to which the patient was quite willing to submit, and, personally, I inclined rather to incise the cervix even in the face of running the risk of setting up pelvic cellulitis, in the hope of thereby increasing the probability of the patient's becoming pregnant. I accordingly divided the internal and external os bilaterally by a straight, narrow, blunt-pointed bistoury (an instrument I consider far superior to all hysterotomes for this purpose) and then inserted a glass stem for three days. The catamenia appeared ten days subsequently, more in quantity, with less pain, and without the colicky twinges in the hypogastrium.

The note taken on her leaving the Hospital ten days after is—Vulcanite stem *in sitû*. The ovary beside the uterus still tender, apparently unchanged.

The subsequent history is briefly this. After wearing the stem two months the patient became pregnant, was remarkably well during the whole of gestation and was delivered easily at full term.

Her statement eight weeks after confinement is that she has none whatever of the old pain in the side nor any vaginal tenderness. She is nursing the baby and has no suffering.

On making a vaginal examination I found almost exactly the old condition remaining, there was still prolapsed ovary lying beside the cervix, and tenderness of the left broad ligament on deep pressure, but the patient's general health is good and she is unaware of anything abnormal internally.

Remarks by Dr. Smith.—The case is of interest as illus-

trating the necessity there is, in all cases of proposed operative interference for ovarian pain by abdominal or vaginal section, to give the duration of the suffering due consideration; also, as enforcing the maxim that all possible uterine causes of the pain must be weighed and treated before resorting to operations directed to the ovaries.

And this I consider of the more importance as it is by no means easy to discriminate between uterine and ovarian symptoms.

These remarks do not apply so much to cases in which there is distinct enlargement of the ovaries and uterine appendages, although even in them they are worthy of the most careful consideration, as to cases of severe dysmenorrhœa and pelvic pain which are attributed to neuralgia and inflammatory exudations affecting and involving the ovaries. I am in the habit of insisting on a history of at least three or four years' suffering before suggesting or acceding to oophorectomy as the proper treatment, and the case here reported is only one of several which justifies that position and illustrates the terrible evil that may be inflicted by a too early resort to that operation.

Judged either from a moral, social, or physiological point of view, nothing can compensate for the removal of the possibility of child-bearing without the most absolute necessity.

The case also suggests that we must hesitate before accepting the doctrine that both ovaries should be removed when oöphorectomy is decided on as the proper course to pursue in the treatment of ovarian pain.

NOTES.

THE SEAL OF THE BRITISH GYNÆCOLOGICAL SOCIETY.

THIS seal, designed and presented by Dr. J. H. Aveling, and executed by Mr. A. Wyon, endeavours to symbolise its motto by representing stars of various magnitudes vying with each other, without envy, in illuminating the world. The crescent is the symbol of Diana, the mythical protectress of matrons.

OÖPHORECTOMY VERSUS PUERPERAL MANIA.

We understand that Sir Spencer Wells has lately removed both ovaries in a patient who had had two attacks of puerperal mania. In one of these she destroyed her child. It seems to us that in such cases Battey's operation finds a happy application. It not only prevents future attacks of puerperal mania, but also guards against the propagation of children likely to suffer from hereditary insanity.

OLIVER WENDELL HOLMES TO FORDYCE BARKER.

At the meeting of the New York Academy of Medicine on February 5, 1885, at the conclusion of Dr. Fordyce Barker's address on retiring from the presidency of the Academy, the following letter from the author of the 'Autocrat of the Breakfast Table' was read to the meeting by Dr. Chadwick, of Boston :—

'Boston : February 4, 1885.

'MY DEAR DR. BARKER,—You must allow me to join my best wishes to those of the friends who will surround you as you take leave of the office which you have filled so ably and happily.

'I trust that you have not forgotten the day when you were with us at the opening of our Boston Medical Library. I know full well that we remember your presence, and how much it added to the pleasure of the occasion. Our Library Association, I hardly need tell you, has proved eminently successful—I want to say because you smiled upon its birth, but I dare not, for you have smiled upon a great many births, not every one of which, perhaps, has had the

good fortune of the infant institution which you joined us in welcoming.

'You may have learned some of our secrets during that visit. Who knows? There are sparks of intelligence still left among us. At any rate, ever since you left Boston we have kept an eye upon you. As soon as it was learned that you had been spending some little time here, you were made president of the New York Academy of Medicine. As soon as you got back, for *some* reason the Academy took a new start, and has been flourishing ever since. All my informants agree about the fact, and they add that it is due to your own faithful administration and energetic efforts.

'We of Boston congratulate our brethren of New York that they have had the great advantage of your services during these last eventful years. The gratitude of the medical profession will keep alive the memory of its past benefactors. We must trust the future for its *vis a fronte*, but in the broadest and loftiest period of progress the leaders will look back to the days of uphill work when our honoured friend lent all his vigour to that *vis a tergo* which they will feel pressing them forward to larger and higher achievements.

'Pardon me for addressing this open letter to you. You can retire "to blush unseen" while some friend is reading it, if it is thought worthy of that honour.

'Always faithfully yours,

'OLIVER WENDELL HOLMES.'

Dr. Franz L. Neugebauer has just published, in the 'Archiv für Gynäkologie,' Band xxv., Heft 2, a further contribution to the etiology of Spondylolisthesis. This new memoir contains forty-three woodcuts and figures the interesting specimen which Dr. Neugebauer found in University College Museum, London.

ALEXANDER'S OPERATION.

On March 12 Dr. Alexander, of Liverpool, came up and performed his operation of shortening the round ligaments for retroflexion in two cases—one at the Hospital for Women and the other in private. Both operations have so far been successful, the uterus being maintained in the normal position. The operation requires care and some experience to recognise and get hold of the end of the ligament where it emerges from the ring, but when this point has been gained the subsequent steps are comparatively easy. We consider the operation will prove of great value in many cases that have hitherto defied all treatment by pessaries.

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INGLUVIN

IN CASES OF DIARRHŒA, CHOLERA INFANTUM, & MARASMUS.

The prevalence of Cholera Infantum, Cholera Morbus, and Diarrhœa, to a greater extent in the summer period, induces us to call the attention of the medical fraternity to the lately introduced remedy 'INGLUVIN.' It has been used in practice with very happy results for a considerable time. We find Indigestion generally at the bottom of bowel complaints, which INGLUVIN has almost instantly corrected alone or in combination. It is given in the following formulas with great advantage:

INFANT FORMULA.		FOR ADULTS.	
℞ Ingluvin gr. xii.	℞ Aqua Calcis..... f ℥ ij.	℞ Ingluvin℥ j.	℞ Aqua Calcis....f ℥ ijss.
Sacch. Lac.....gr. x.	Spts. Lavand. Comp.,	Morphiæ Sulph. gr. jss.	Spts. Lav. Comp. f ℥ ss.
	Syr. Rhei. Arom. aa f ℥ j		Syr. Rhei. Arom. f ℥ vi.
Misce et Ft. cht. No. x.	Tr. Opii.....gtt. x.	Misce et Ft. cht. No. xii.	Tr. Opii f ℥ ss.
Sig.—One every 4 hours.	Misce. Sig.—A teaspoonful every 2 to 4 hours.	Sig.—One every 4 to 6 hours.	Misce. Sig. — Dessertspoonful every 2 or 4 hours, or after each evacuation.

In inflammatory affections, INGLUVIN is combined with Subnitrate of Bismuth, equal parts, and oleaginous mixtures with Ol. Terebinth, instead of Aqua Calcis. Should the evacuations be suddenly arrested, and tympanites supervene, follow with a dose of oil or magnesia, or injections. In many cases of sick headache and indigestion, the most happy results follow from the combining of INGLUVIN with Pv. Nux Vomica, the one-twentieth to one-tenth grain.

Marasmus successfully treated with INGLUVIN.—See Article below.

TABEO-MESENTERIC DISEASE.

1 ELDON SQUARE, NEWCASTLE-ON-TYNE, ENGLAND,
October 31*st*, 1880.

DEAR SIRS,—Will you have the kindness to inform me if you have an agent in this town for WARNER'S INGLUVIN, as I shall most likely prescribe it from time to time, in order to give it a more extended trial I was much gratified with its action in a distressing case of Tabeo-Mesenteric Disease. I had no difficulty in bringing the pain under subjection by opiates, &c.; but in the vomiting, emaciation, and disordered condition of the bowels, there was no improvement. Finding a sample box of INGLUVIN upon my consulting table (and for which accept my thanks, for I firmly believe that the powder saved my little patient's life), I gave the mother the box containing a dozen powders, requesting her to divide one into three, and administer one twice daily. The pain disappeared, the vomiting ceased, flesh was rapidly put on, and in the short space of a fortnight the patient (previously under treatment for six weeks) was convalescent and completely recovered (aged 2½ years).

Believe me, yours faithfully,

ANTHONY BELL, L.R.C.P.Ed., M.R.C.S.Eng., L.S.A., &c.
Late Senior Assistant to the Newcastle Infirmary, and Surgeon to the Hospital for Diseases of the Skin, &c.

PER BOTTLE 4s. 6d.

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THE BRITISH GYNÆCOLOGICAL JOURNAL

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THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, APRIL 8th, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 35 Fellows, 4 Visitors. The following gentlemen were elected Fellows of the Society:—Dr. T. B. Grimsdale, Liverpool; Dr. A. R. Hopper, Liverpool; Dr. Rufus B. Hall, Ohio, U.S.A.; Dr. Henry Hadley Smith, Massachusetts, U.S.A.; Dr. W. Fearnley, London.

The following gentlemen were proposed for election:—Dr. John Ford Anderson, London; Dr. Francis D. Hamilton, London; Dr. James Williams Danaher, London; Dr. Edward W. Thurston, Ashford; Mr. William Knight Treves, Margate; Dr. R. S. Sutton, Pittsburgh, U.S.A.

Mr. Keith, of Edinburgh, was nominated as an Honorary Fellow.

Dr. FANCOURT BARNES showed, for Dr. Neugebauer of Warsaw, some photographs of patients with kyphoskoliosis and spondylolisthesis.

Dr. EDIS exhibited a fœtus of six months' development which he had removed that afternoon from a patient under

his care in the Middlesex Hospital. The case was one of extra-uterine gestation occurring in a multipara aged 41; married nine years; mother of three children, the youngest four years old; one miscarriage two years since. The catamenia ceased on October 12 for two months. On December 10 a sanguineous discharge appeared, and remained on and off until February 12, the patient experiencing much pain in the right iliac fossa and being obliged to keep her bed during these two months. She then sought relief for dysuria of three weeks' duration, complete retention for two days. On examination a tumour was found occupying the right lower abdomen, extending up to within two inches of the umbilicus. Per vaginam, a fœtal head was detected low down in the pelvis behind and to the right of the cervix uteri, which was soft, fleshy, and much enlarged. The Paquelin thermocautery knife was employed to cut through the vaginal surface of the cyst. The fœtus, which had been dead some two or three days, was then removed, the placenta being left untouched.

Dr. WALTER (Manchester) made some remarks on the difficulty that attended the diagnosis of diseases of the Fallopian tubes after the tubes had become fixed to the surrounding parts, and enclosed as it were in a mass of peri-uterine cellulitis. This complication was most likely to occur in pyosalpinx, and obscured the physical signs upon which the diagnosis largely depended.

Dr. AVELING said the practice of leaving the placenta was recommended by Dr. Ryan forty-five years ago. He says: 'The placenta should be left attached in extra-uterine pregnancy lest fatal hæmorrhage ensue. The wound should be left open to allow the discharge of liquor amnii, blood, membrane, placenta, or purulent matter' ('Manual of Midwifery,' p. 293).

Dr. BARNES concurred in the treatment of leaving the placenta *in sitû*. He referred to the late Dr. Ramsbotham as having been one of the first to advise the practice of *not removing the placenta* if it were in any degree adherent. It is

advisable to tie the funis and let its end hang out of the wound. It gradually softens and breaks down, and in a few days will come away in lumps or small débris.

A Case of Double Pyosalpinx, by JAMES H. AVELING, M.D., Senior Physician to the Chelsea Hospital for Women.

R. C., aged 23, was admitted into the Chelsea Hospital for Women on February 14, 1885. She had been married eight months. The catamenia were regular, moderate in quantity, lasted three days, and were not accompanied by special pain. The flow was present when she was admitted. She enjoyed good health, but was liable to momentary attacks of pain in the lower abdomen. She had never in any way been unfitted for active work. For more than two years she had noticed a swelling in the left ovarian region, and thought it was getting larger. She had no dysuria or dyschezia. No history could be got of any vaginal discharge, cold, or inflammatory attack of any kind. The urine when tested showed a distinct cloud of albumen, and a systolic apex murmur could be heard. There was no history of rheumatic fever. The lungs were healthy and her general condition good. The temperature was normal.

Per vaginam, examination revealed the uterus pushed back by a smooth, round elastic tumour. By bimanual examination this tumour was found to be an ovoid mass reaching to the umbilicus in a line with the axis of the abdominal cavity. It was freely movable from side to side. The right side of the uterus, which was normal in length, was more fixed than the left, and a swelling could be felt there, rather tender when pressed. There was dulness on percussion over the tumour.

After consultation with my colleagues, Drs. Edis and Fancourt Barnes, we came to the conclusion that the tumour was ovarian, and that an operation was necessary.

This was performed by myself on February 26. Upon opening the abdominal cavity a cyst presented itself which was found to have no adhesions and attached by a short

pedicle to the left of the uterus. It was the size of a small elongated cocoanut. To the right of the uterus another tumour was discovered, a little smaller than the first, and bound down in the pelvis by extensive adhesions. These were all carefully divided by the fingers. It was now found that the pedicles could not be reached nor the cysts lifted out of the abdomen, although the incision was extended to the umbilicus. The first cyst on the left was therefore tapped, and the result was a flow of pure, sweet pus. A ligature was then passed round the pedicle and the cyst removed. The second was treated in the same way, but unfortunately in making traction the cyst gave way and pus escaped through the laceration to the amount of about an ounce, some of it, I fear, running into the abdomen in spite of our utmost care to prevent it. There was very little bleeding, and the sponges used for cleansing the pelvic and abdominal cavities came away little soiled. The wound was closed in the ordinary way and the patient put to bed.

I need not take up your time with details of the distressing termination of this case. Acute general peritonitis at once set in, with great abdominal distension and all the ordinary symptoms which are too well known; and in spite of every effort to save her, including opening the wound and syringing and drainage, and puncturing the intestine with a small trocar, which gave great temporary relief by removing the distension caused by flatus, the patient died on the eighth day.

The tubes are now exhibited, much shrunk by being in spirit and glycerine. The two contained fifteen ounces of pus.

Several points of interest in this case have induced me to bring it before the Society. It is exceptional in many ways. No previous history of gonorrhœa or vaginal inflammation could be obtained, nor had the patient suffered at any time from symptoms of pelvic inflammation. The ordinary diagnostic signs of pyosalpinx were nearly all absent. There was no rise of temperature and no menorrhagia. No irregular swelling could be detected through the roof of the vagina; in fact one tube had risen out of the pelvis, and both

would probably have done so had the right not been prevented by adhesion. There was nothing symmetrical about this case, one tube being free and high and the other bound and low. Neither, therefore, in shape, position, nor relation, could it be easily differentiated from ovarian disease. Another peculiarity of this case was its fatal termination. It is not a pleasant occupation publishing one's failures, but it is a wholesome practice and has its compensating advantages. The confession of a difficulty or disaster leads more than anything else to discussion, and the eduction of generous criticism and valuable information. A fear of doing this infers a distrust in the kindness and good-fellowship of our associates—a doubt which it is hoped will never be entertained by any Fellow of this Society.

Three Cases of Pyosalpinx by LAWSON TAIT, F.R.C.S., Surgeon to the Birmingham and Midland Hospital for Women.

The case which has just been read by Dr. Aveling furnishes an example of a form of pyosalpinx which is very rare and which one may liken to the collection of pus which elsewhere is known as the cold abscess. I have had two or three examples of it, and I have seen another and very fine specimen exhibited by Mr. Knowsley Thornton in which the quantity of pus amounted to some pints, if I remember exactly, in the two tubes. In these cases pain is not a leading feature, the existence of adhesions seems to be exceptional, and the interference with the disease is brought about generally by reason of the discovery of tumours. Exactly the same kind of remarks are true about hydrosalpinx, and we not unusually see cysts of a Fallopian tube of very considerable size and importance occurring along with ovarian tumours. An example of this kind of pyosalpinx was furnished to me very early in my experience of the disease in the case of a young blonde lady, from whom I removed both tubes on account of their existence as large tumours occupied by thick pus. The preparations are in the Museum of the

Royal College of Surgeons. In this case she had somewhat profuse menstruation and some pain at the time, but her symptoms did not amount to the extreme menorrhagia or to the agonising pain which the more acute form of the disease brings about. In removing the tubes in her case both burst and the pus was scattered about all over the peritoneum, requiring very careful and extensive washing and sponging to remove it, and a drainage tube was used for five days. It is now nearly five years since the operation was performed, and she remains in perfect health and is in prospect of marriage before long.

A very remarkable contrast to this is shown in the case of Mrs. M., aged 36, married for four years; no children; brought to me by Dr. Pike, of Malvern, in January last. Her menstruation was regular, lasting for a week, extremely profuse and accompanied by great pain, the pain coming on several days in advance of the period. She had suffered from repeated attacks of pelvic peritonitis, on more than one occasion the disease seeming to become general so that her life was despaired of. The uterus was felt to be anteflected and completely fixed, with a mass, ill-defined, and very tender on pressure at the back of the uterus. The diagnosis was given that she was suffering from pyosalpinx, and an operation was recommended. With this view Dr. Pike concurred, in fact he had previously made a similar diagnosis. The operation was performed on February 25, and great difficulty was encountered in removing the loops of intestine which were glued on to the roof of the pelvis. The right tube was finally discovered low down and completely adherent. During its separation a sponge was found to be discoloured by a small quantity of thick matter, which looked exactly like fæces, but from which no fæcal odour was observable. But even though this negative indication made me hope I was mistaken, I was very fearful that I had torn a piece of intestine in separating the adhesions. I persevered with the operation, however, and removed the right tube and ovary. An almost similar difficulty was encountered in removing the

left appendages, the operation being extremely tedious and difficult. The pedicle was secured in the usual way by the Staffordshire knot and a long drainage tube inserted quite to the bottom of the pelvis. Her recovery was perfectly easy and simple and she went home on March 25. Both tubes were found to contain dark yellow pus which had all the appearance of liquid fæces. In this case no history could be given of the origin of the disease, but from the fact that she had never been comfortable during married life and had been ill more or less ever since, it may be assumed that it had some catarrhal origin antecedent to marriage.

E. H., aged 22, came under my care for the first time about four years ago, suffering from one of the most severe attacks of gonorrhœa which I had ever seen. She was a very long time, nearly a year, in getting free from the vaginitis, and during the whole of that time she suffered from constant pelvic pain and profuse and painful menstruation. I became perfectly satisfied that she was suffering from pyosalpinx and strongly advised her to allow me to operate for its relief. The idea of operation, however, somewhat frightened her, and for some considerable time she absented herself from attendance at the hospital. I again saw her about the end of 1883, her sufferings having been in the meantime in no way lessened, and she had become quite incapacitated for work and was a complete invalid. She again declined to accept my advice and placed herself under the care of another practitioner, who, after various attempts to relieve her, brought her again to me early in the present year, by which time she was desirous to submit to anything which would afford to her a prospect of relief. I operated upon February 12, and had the utmost difficulty in removing the tubes, which were large, thick, and almost cartilaginous in texture, containing about a teaspoonful and a half of pus in each. She made an extremely easy recovery, neither temperature nor pulse record ever reaching more than fractionally above the normal standard. She went home about five weeks after the operation.

The second and third cases illustrate what is by far the most common kind of the disease, where the inflammation affects the substance of the tubes on their outside, differing altogether in its character from that shown in the first cases, where apparently the inflammatory action is limited to the mucous lining. The symptoms of the disease are almost uniform. We have painful and profuse menstruation invariably, the pain always appearing a day or two, sometimes a week, before the period, increasing in intensity and lasting the whole of the menstrual time. The pain is also almost always greater upon the left side than upon the right. In a great majority of the cases we are given a history which gives rise to the suspicion of gonorrhœal infection, but in other cases the disease occurs after a miscarriage or after one of the zymotic fevers, and occasionally we cannot get any history of the onset at all. The physical signs are that the contents of the pelvis are more or less fixed, that a mass can be felt behind or to one or other side of the uterus, which mass in many instances can be defined as a sausage-like convoluted tumour, indicating clearly the distension of the Fallopian tube. There is always very marked dispareunia, this in the majority of the cases being extreme, so that the marital function has to be completely suspended.

It is, of course, impossible to make a differential diagnosis between pyosalpinx, hydrosalpinx, and hæmatosalpinx, and there may also occur an occasional error in cases of tubal pregnancy at the time of rupture. Such distinctions can only be made at the time of the operation, but chronic salpingitis with occlusion and distension of the tubes is a condition which is easily diagnosed, and it is one which can only be cured by removal of the diseased organs.

The outcome of these operations is extremely satisfactory, the mortality is very small, and the relief which follows the operation is, in the great majority of instances, immediate and complete. In others menstruation will go on for some months, but with greatly diminished suffering and much less in quantity, and, although in some of these instances pain

remains to a considerable extent, yet relief always comes in time, and the patient's condition ultimately becomes one of perfect cure. They constitute a class of cases which, together with those suffering from chronic ovaritis, wander about from practitioner to practitioner and from hospital to hospital seeking relief, and after every kind of treatment has been used in vain, they at last come to the operating surgeon for the only means which will give them satisfactory assurance of complete cure. There can be no doubt that in many cases lives are lost, as has been shown by the papers of Dr. Kingston Fowler, and great risks run, as shown by the recently published case of Mr. Frederick Treves, by unnecessary and unwarrantable delay in dealing with these cases. The difficulty of diagnosis, which will probably be largely felt, ought not to interfere with the surgical treatment of these diseases, because it does not in any way interfere with surgical treatment of diseases elsewhere in which an exact diagnosis cannot be made. Take, for instance, the common case of tumours of the breast; it is perfectly impossible in a large number of instances to make an accurate diagnosis of the exact nature of the tumour, but no one hesitates on that account to remove it. Whilst the diagnosis is thereby rendered complete, the only means of relief which we can hold out to the patient is at once afforded her.

Dr. BANTOCK exhibited a specimen of hydrosalpinx as illustrating another form of disease of the Fallopian tubes, for a knowledge of which they were so much indebted to Mr. Lawson Tait. There was also a small solid ovarian tumour in an early stage of degeneration and breaking down. The specimens were obtained from a lady aged 32, married but sterile, who had been an invalid for many years. When first seen by him at the end of last year, there was a small rounded swelling on the left side which he regarded as ovarian, and on the right side of Douglas's pouch, pushing the uterus forwards, a larger and softer swelling, whose outline was not so easily defined, and which he took to be Fallopian, but of the exact nature of which he could not form

a definite opinion. The patient had undergone a great deal of local uterine treatment during several years, including the use of pessaries. Menstruation was excessive and painful, and the patient had a great deal of pain in the intervals, and the periods were usually accompanied with so-called bilious attacks. He recommended abdominal section on the grounds that the disease could not be cured by any constitutional treatment, that there was danger to life if nothing were done, and that there was a fair prospect of success in removing the diseased parts, though the patient readily accepted his advice. It was decided, however, to postpone operation for a month or two. In the meantime the patient was kept quiet in bed—as she had been for several months. Under the influence of rest the menstruation became less abundant and less painful, and during the period preceding the operation she had no sickness.

The operation was performed on March 10, 1885. The tumour on the left was separated with great difficulty from the bottom of Douglas's pouch and back of the broad ligament and its pedicle secured by fig. 8 ligature. There were also some filamentous adhesions to intestine. That on the right side, which was at once seen to be cystic, and recognised as a hydrosalpinx, was also adherent. The very tense and attenuated membrane soon gave way, evacuating about half a pint of a dark coloured fluid, like weak tea, and the cystic portion could not be separated until he had ligatured and divided the tube near the right corner of the uterus. The remaining portion was then separated. On the right side he could not find the ovary, and on the left he was unable to define the tube. As there was considerable oozing he washed out the pelvis with warm water, and then packed Douglas's pouch with sponge, while the abdominal sutures were being put in. Finally, a drainage tube was inserted and the wound closed. The patient made a very good recovery, the temperature never having exceeded 100·4°.

Dr. BENINGTON said he had at present under his care a patient whom he believed to be suffering from a pyosalpinx,

which had apparently opened into the rectum. He wished to know if Mr. Lawson Tait would regard this complication as a bar to operative interference.

Dr. HEYWOOD SMITH asked Mr. Lawson Tait whether in those cases where he had removed the oviducts and left the ovaries there had been any effect on menstruation.

Dr. RUFUS B. HALL, of Ohio, had witnessed several of Mr. Lawson Tait's operations in cases of pyosalpinx, and had examined some of them before operation. He had no difficulty in detecting the sausage-like mass behind the uterus, which was generally diagnostic of the condition. He should not hesitate to open the abdomen in similar cases on his return to America.

The PRESIDENT remarked that the subject under discussion might be regarded as one comparatively new to gynæcologists, and he ventured to think that before long it would prove to be another triumph won by the gynæcological operator. He did not believe there was, or would be, any difference of opinion between them as to the proper treatment applicable to these cases; certainly not in regard to cases of pyosalpinx, probably not in cases also of hydrosalpinx. But, while agreeing with all that had been urged as to the best mode of treating these cases, he considered that at present something had yet to be learned in the matter of diagnosis. For himself he confessed he was by no means satisfied as to the facility with which these cases could be diagnosed with any approach to certainty, and he urged the importance of more closely studying the clinical phenomena which these cases presented. According to Mr. Lawson Tait, whose experience in these diseased conditions was, he believed, unrivalled, there appeared to be three points which were specially to be noted: first, menorrhagia; secondly, pain occurring for a few days before menstruation appeared; and, thirdly, the discovery of the peculiar sausage-like swelling which was to be felt per vaginam. But, with regard to the two first symptoms, it was obvious that both might occur in many other conditions besides that of diseased Fallopian tubes; and

with regard to the last it was, he believed, very difficult to differentiate these swellings from others due to totally different diseases. At present, therefore, he contended for more minute clinical observations, which would place these conditions on a surer diagnostic basis; and when that was assured he believed there would be no difference of opinion among practical gynæcologists as to the treatment which should be adopted. He had almost as little fear of opening the peritoneum as had Mr. Lawson Tait, and he felt convinced that this advancement in gynæcological surgery marked one of the greatest triumphs in modern operative practice, and opened up a brilliant future for the operative gynæcologist.

'*Plural Monstrosities*,' *by* R. ORFORD LAMPREY, L.R.C.P. & S.

In bringing the subject of this short paper before the notice of this meeting, I feel I am under the necessity of infringing one of the observations enunciated by the President in his inaugural address when he suggested we should not bring into too prominent a position researches of the library.

As far as the specimen before you is concerned it speaks for itself; it has simply been my fortune to obtain it owing to a miscarriage of the third month. There was nothing to call for special notice at the time, nothing, in fact, beyond what you find in an ordinary miscarry. The mother is about 22 years of age. This was her second pregnancy. The first child is living and free from any imperfections, and there is nothing suggested to account for the present strange development, which is not so common as to be cast aside, or so rare that it should be considered marvellous; the interest attaching to it is singular, and partakes more of the character of a 'lusus naturæ.' There are other forms of monstrosities extant where parts of the child are in duplicate. We have instances of double sets of the upper or lower extremities; two heads; and, in short, the combinations are almost endless, as may be seen by a visit to any pathological museum. In all such cases the union is anatomically symmetrical; it seems this

rule is never violated. Thus we have the union of sacrum to sacrum or abdomen to abdomen, and in one case two children were joined together at the top of the head, end to end, which is noteworthy and curious. Part of the back or side seems to be the most favoured position for the connection. There is an exact representation of the specimen before you in one of the plates in 'Ramsbotham's Midwifery,' taken from a preparation in the London Hospital Museum. You will see in this monstrosity the lower halves of the two sternums and the whole of the abdomens are united so intimately that, had the children arrived at maturity and lived, it would have been extremely difficult for one of them to walk forwards without the other walking backwards, or, supposing they walked sideways, the pelvis of each would have to rotate in great measure upon the lumbar vertebræ or lumbo-sacral much more so than we are able to accomplish, but which might possibly be acquired to a certain degree or extension if nature was called upon to perform such a movement from the very earliest stages of infancy. You will perceive the position of the arms is not natural. This was unfortunately caused by dropping the specimen into the bottle of spirit where it lay during the night I received it. When I proceeded to mount it next day I was unable to get the arms to resume their former natural position; I therefore considered it better to leave them alone, fearing matters might become worse. Had these children come to their full time there is no doubt they would have caused a long, painful, and exhausting labour. Yet I think that already nature was making preparation for this occurrence, for, if you look closely you will find that one child is rather larger and taller than the other. By this arrangement the head of the shorter one would most probably fit into the hollow of the neck of the other during the descent through the pelvis. This is, I believe, the most frequent and natural way for the birth of such monsters.

The physiological aspect may next claim our attention, and I should say it was caused by the partial agglutination of two seminal filaments impregnating two ova at the same time

which had escaped by the rupture of two mature Graafian follicles; or *vice versâ*, by two agglutinated or double ova becoming impregnated by two separate and distinct seminal filaments. Perhaps this latter hypothesis is the better.

It is remarkable and strange the similarity and likeness between children of a plural birth. This is no doubt more striking owing to the children always corresponding in age and size.

There is nothing in our artificial manner of living that seems to favour these developments. They come from all countries, civilised and uncivilised, and have been handed down to us from time immemorial. Of this there can be no doubt, since heathen mythology abounds in many examples, though they are dressed up in poetical, fantastical, and exaggerated garbs. Such are the many-headed and many-handed gigantes or giants—Geryon, with three heads and three bodies; Janus, the two-faced. Then, again, Cerberus, a dog with three heads; and this recalls to us that in the lower forms of animal life there are frequent and strange anomalies, so that the idea of impressions made on the mind giving rise to these monstrosities ought to be received with caution.

That plural developments often survive parturition, and even attain to long years, is amply proved, and there is every probability of the present compound now being exhibited in London, Millie Christine, the African 'Two-headed Nightingale,' who have attained their thirty-fourth year, living to a good age. They are in the enjoyment of excellent health, and show no sign of premature decay. When they do go it may be a long time before another living example is presented to us; but with modern improved obstetrics and improved appliances these curious developments will have a better chance of being born alive.

The Society then adjourned.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, APRIL 22nd, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 34 Fellows, 5 Visitors. The following were elected Fellows of the Society:—Drs. J. Ford Anderson; W. K. Treves; J. W. Danaher; F. D. Hamilton; E. W. Thurston; R. S. Sutton, Pittsburgh, U.S.A.

The following were proposed for election:—Drs. G. M. Carfrae; E. R. Evans; W. L'Heureux Blenkarne; John Mackie; A. J. W. Keenan; A. E. Prockter; L. Fuller; Surgeon-Major F. H. Hensman; and Dr. W. Jaques.

Mr. REEVES showed a kidney which had been converted into cysts by calculous pyelitis. It was taken from a woman admitted into the Hospital for Women under the care of Dr. Carter. She was extremely blanched, being the subject of profuse metrorrhagia. This subsided under treatment when hæmaturia came on. On examination nothing wrong could be detected in the bladder or urethra. She subsequently complained of pain in the left flank, and on palpation the kidney was felt to be much enlarged and tender. No history of urinary trouble could be obtained from the patient, but the mother stated that her daughter's water had been very offensive, and adhered to the utensil. This certainly was not the case while she was in hospital. After consultation it was decided not to explore the kidney, as the patient was so anæmic and weak. A few nights after she awoke, and on trying to rise in her bed said, 'Oh! I feel so faint,' and fell back dead. The cause of death was syncope from asthenia,

due to repeated hæmorrhages. At the post-mortem the left ureter was found to contain a long narrow calculus, which projected into the pelvis. This and a large part of the rena substance were converted into several cysts. The other organs were normal.

Mr. Reeves also showed a renal calculus successfully removed by nephrotomy, and alluded to other cases which had been under his care. He also showed an interesting specimen of salivary calculus which had been mistaken for cancer in the floor of the mouth.

Dr. FANCOURT BARNES showed some medicated vaginal tampons made for him by Messrs. Burroughs & Wellcome. The tampons are composed of absorbent cotton wool and elastic fibre, enveloped in sublimated gauze. In the centre of the wool is a small hermetically closed glass capsule, containing the drug in a concentrated form. Before applying the tampon to the vagina the capsule is broken by pressing the tampon between the finger and thumb, and thus liberating the contents, which are diffused through the tampon. In this way iodoform, cucaine, eucalyptol or any other drug may be preserved intact and ready for use when required.

Dr. BANTOCK suggested that the tampons should not all be charged with sublimate. It was well known that some persons were peculiarly susceptible to the action of mercurials. Death had occurred in several instances from the use of this substance in the form of a very weak solution as a vaginal injection. If the sublimate were efficient, then he did not see the necessity for the other substance; and if not efficient, he did not see the necessity for it, or even the advisability of using it.

Dr. AVELING thought them much more convenient and cleanly than the ointment pessaries. He asked Dr. Fancourt Barnes if he applied the pessaries dry.

Dr. FANCOURT BARNES showed, for Dr. Lundy, of Feltham, a nine months' fœtus which had been expelled by a multipara in a natural labour. The child, a male, was completely enveloped in the membranes, with the cord and

placenta attached. The limbs were flexed as in the intra-uterine posture. The liquor amnii only had escaped. Dr. Fancourt Barnes said he regarded the specimen as unique. He had never seen the complete ovum expelled at term in its entirety.

Case of Sloughing of Vagina after Confinement, with Septicæmia. Recovery. By J. CHALMERS, M.D., District Surgeon to the Royal Maternity Charity.

Mrs. C——, aged twenty-four, a delicate London-bred girl, was delivered of her first child at full term, on January 28th last. Labour lasted for eleven hours; for three hours strong expulsive pains continued, and during the last two hours the head pressed more or less upon the perineum. The patient showing signs of exhaustion forceps was used, and the child delivered with very little force. There was slight rupture of the perineum, but the posterior part of the vagina was torn, and there was general bruising of the outer part of the vaginal canal. Six hours after labour the temperature was 102°, pulse 124, but these gradually subsided to the third day, when the temperature was 99·8° and the pulse 96. On the second day patient complained of great pain in the region of the uterus. During the evening a clot passed, and next morning the pain had gone, and during the whole subsequent illness there was an almost entire absence of pain. On the fourth day there were signs of septicæmia. The pulse rose to 116, temperature to 100·3°, and there was diarrhœa; tongue fairly clean and moist. On the sixth day the pulse rose to 132, temperature 101·5°. Tongue clean, milk drying up. Patient in an emotional condition, distressed with a rising or choking sensation in the throat, which continued for some days. She feels faint, sleeps little or none, no delirium, no sickness, no shivering, has had no rigor. Diarrhœa has become frequent and expulsive. Complains of no pain of abdomen. Condy's fluid had been used by nurse daily to wash out the vagina: to-day I washed out the uterus, bring-

ing away a few small clots of blood, and a few lumps of mucus. This was repeated every day. The raw surface of the vagina healing, the black slough of external ring separating. (I noted here that the healing process went on satisfactorily for several days, even although the septic influence was in progress.) On the seventh day the tongue became foul; a yellow fœtid discharge from the uterus showed itself, in spite of daily washing out of the uterus. Following on the appearance of a free fœtid discharge, the raw surface took on a grey unhealthy look; temperature 100·8°, pulse 140, and wanting in tone. In the morning of the eighth day the temperature was 100·8°, pulse 140; mid-day pulse was 130, temperature 102·8°; at night they rose to 146 and 103°. Bowels tympanitic and diarrhœa frequent. Patient looks flushed and anxious. To-day, Dr. Fancourt Barnes saw the patient with me, and we both came to the conclusion that death was imminent. Dr. Barnes recommended digitalis in addition to opium and quinine, which had been used, and to use carbolic acid for injection as being more volatile, and more likely to diffuse itself into the interstices of the uterus. The effect was satisfactory. Next day patient seemed considerably better, as regards abdominal mischief, but a new symptom appeared. A slight cough, which had shown itself several days ago, now developed into a distinct bronchitis with profuse expectoration and much coughing; and this gradually deepened into congestion, inflammation, and consolidation of the posterior and lower parts of both lungs, chiefly of the left side. About the twelfth day the general condition was better; expectorations much less, discharge in vagina nearly stopped, wounds healing. But a condition as of thrush attacked the cavity of the mouth and several diphtheritic-looking patches showed themselves about the tonsils. These were painted diligently with boracic acid and glycerine, and they ultimately did well. The temperature and the pulse now gradually fell to 99·8° and 110 on the fourteenth day. Pulse good in tone; patient taking food well. Ulceration of vagina nearly healed. Diarrhœa, however, still con-

tinues. No continuous sleep. Expectoration again profuse. Septicæmic condition evidently coming to an end; but as the diarrhœa continued and was more profuse, and the patient was getting very feeble, I ordered injections of powdered catechu and opium, which checked the action of the bowels. On the nineteenth day the pulse went up to 106, temperature to 101·6°. Why? On seeking for an explanation of this sudden rise of pulse and temperature, I thought it was probably because the poison which was being eliminated by the evacuations was now being pent up and diffused through the system. Enemas were given and hard fæces removed. This was followed by free purgation by calomel and jalap. No immediate amelioration of the symptoms followed the opening of the bowels. The constipation had probably another bad effect, for on the twentieth day, three days after the bowels ceased to act, the patient's cheeks became flushed; this was supposed to be due to some ale she had been drinking, but the flushing developed into a rash which extended itself down the neck. A few itchy spots upon the wrists then showed themselves. Next day the eruption on the face and neck had become confluent, and the limbs and body were overspread with a dusky red raised rash, closely resembling measles, most profuse on the chest and arms. On the twenty-fifth day of the attack, and fifth of the eruption, I note the rash as being profuser than ever, except on the face, where it has already faded. There has been no sneezing, but the patient complains of her eyes smarting and watering, and on examination I find they are suffused with red and the palpebral conjunctivæ of a deep scarlet. For two days the eyes had to be shaded from the light. On the twenty-eighth day, and eighth day of the eruption, the rash had practically disappeared, and some days later the skin began to peel in flakes off the fingers and palms, and off the body in scales, after the manner of scarlet fever. During the progress of the eruption the temperature and pulse gradually fell from 103° and 133 to 99° and 100; tongue perfectly clean and healthy looking bowels acting

regularly. Shortly before the rash broke out, the quinine, digitalis, and opium had been withdrawn as being no longer necessary, and as the broncho-pneumonia continued, with breathing much embarrassed, ipecacuanha, ammonia, and tincture of bark was administered. On the twenty-third day I note a fresh outbreak of marked ulceration on the inside of the lips and cheeks. On the twenty-fourth day, while the chest symptoms were improving, the bowels acting regularly, the pulse and temperature going down, and the day before the eruption reached its height, a new phase of the ailment showed itself. It appeared as if the ailment, having passed from the abdomen to the chest, now invaded the third cavity of the body. No aberration of the mind had been noted, although the nurse, now that her attention was drawn to it, stated that the patient did wander a little at times, especially during her short snatches of sleep, but at this date the brain became distinctly confused and excited. Next day the patient was very delirious, by day as well as by night, and had pain in the head as well as in the eyes; next night she got up in her sleep and walked into the next room while her nurse dosed. This delirium lasted for four or five days, gradually subsiding. Then the patient had a sound sleep and woke next morning to be troubled no more in any distinct form, except by a gland in the femoral region, which swelled and became inflamed and painful, but by-and-by subsided. On the twenty-eighth day the pulse was 88, her temperature normal. She was weak but coherent, sleeping well and eating well and gathering strength. About the end of March she was out and about, apparently in her usual health. The points of interest about this case seem to be: first, the sloughing under so little pressure; second, the absence of pain except on the second day; third, septic influence attacking the three cavities of the body in turn; fourth, the eruption and its cause; fifth, the recovery of the patient under such grave and complicated conditions. In the sixth place I may note, in evidence of the virulence of the septic products, that the nurse had to go home with malaise and ery-

sipelas of both legs. The doctor had an angry pustule on the wrist, and the second nurse suffered from a severe attack of diarrhœa; and, from having received some of the patient's liquid fæces on her hand, the tender skin between the fingers was blistered, and an itching of the skin of nearly the whole hand was set up, which lasted for several weeks.

Mr. LAWSON TAIT thought that Dr. Chalmers' case was a very interesting one from many points of view. He had often noticed after surgical operations the peculiar rash closely resembling scarlet fever, and followed by the conditions which had been alluded to by Dr. Chalmers. Some of the cases had recovered and others had not. He had shown the eruption to practitioners more conversant with the appearance of scarlet fever than he himself was, and they had been quite unable to point out any distinction between the two. Many of the characteristic symptoms of scarlet fever were, however, entirely absent in these cases, but desquamation always occurred if the patient lived.

Dr. ROUTH asked if Mr. Lawson Tait's patient had had a previous attack.

The PRESIDENT considered that Dr. Chalmers' paper was one of peculiar interest. First, because cases of gangrene of the vagina were very rare; and secondly, because such cases, being always of extreme gravity, very frequently ended fatally, while Dr. Chalmers' case recovered. There was also the further interest in this case that a great variety of symptoms successively occurred as a consequence of successive attacks of septicæmia, and this fact seemed to throw some light upon the vexed question of the specific character of the so-called puerperal fever; for there could be no doubt that in this case identically the same poison was being repeatedly absorbed, while the resultant symptoms varied very considerably; whether or no this variation was due to the possibly varying amount of the poison absorbed it was of course difficult, if not impossible, to say, though it seemed not altogether improbable. He thought that Dr. Chalmers was to be congratulated on the success which had attended his management of the case; and

the Society was also indebted to him for the way in which he had recorded it. It was just the kind of paper which he (the President) had in his Inaugural Address ventured to hope might often be brought before the Society, the record of a carefully observed case, with its clinical phenomena well and accurately described, and the therapeutical indications and results graphically and minutely observed and told. There was, however, one point in the treatment of the case which he ventured to criticise and take exception to, viz., the administration of opium during the occurrence of the septicæmic symptoms. He (the speaker) believed it might be laid down as a law of almost universal application, that any drug which tended to check secretions and to lock them up in cases of septicæmia was to be carefully and rigorously excluded; he noticed that in this case, when opium was given so as to confine the bowels, there was at once a marked aggravation of the symptoms, and this he believed would be found to be an almost invariable rule. In all other respects he certainly concurred in the opinions advanced by Dr. Chalmers.

Mr. REEVES suggested that if the gangrene had been treated locally, according to ordinary surgical principles, the sloughs removed and the parts cauterised, the danger of septicæmia might have been much diminished. He thought that Dr. Chalmers had most likely administered opium in the view of checking the gangrenous process, and this was according to recognised surgical rules; but when septicæmia supervened, and it became necessary to relieve pain, he thought that chloral or paraldehyde would have answered the purpose, and would not have interfered with the emunctories.

Dr. BANTOCK said he was able to confirm the remarks of Mr. Lawson Tait as to the occasional occurrence of a rash after abdominal operation. This rash somewhat resembled scarlet fever in its appearance, but there was a decided difference. It was not accompanied by sore throat, but was followed by desquamation. The most severe example he had seen was in a case of serious carbolic poisoning with hyperpyrexia and acute desquamatic nephritis. For the most part it

was not accompanied by serious constitutional disturbance. It had been taught that scarlet fever poison often produced puerperal fever. He could not accept such teaching. He had seen scarlet fever attack the puerperal woman, but the disease had always removed scarlet fever. He did not believe in the interchangeable theory. With regard to the use of opium, it was rather remarkable that Mr. Lawson Tait and himself had been discussing this question just before the meeting, and they found that they had arrived at the same conclusion from independent observation; and he was now in the habit of omitting the usual opiate after operation, and apparently with decided advantage.

Dr. CHALMERS, in reply, remarked that in giving opium he had in view that in this case all the secretions seemed to be in active operation. He opposed the view that specific zymotic infection in the puerperal woman produced specific forms of septicæmia, as puerperal scarlet fever, puerperal erysipelas, &c. He believed from observation that where zymotic infection occurred, the disease was either modified by or got lost in the general puerperal condition.

Some Points in the Treatment of Uterine Fibromyomata. By THOMAS MORE MADDEN, M.D., F.R.C.S.E., Obstetric Physician Mater Misericordiæ Hospital, Physician to the Hospital for Sick Children, Consulting Gynæcologist Dublin Provident Infirmary, Vice-President British Gynæcological Society, formerly Examiner in Obstetric Medicine and Gynæcology Queen's University in Ireland.

As the respective merits of the various operations now employed in the treatment of fibromyomata are still *sub judice*, I venture to submit some observations on the methods of dealing with these tumours, of which I have had clinical experience in my hospital practice. My chief purpose in so doing is the hope of again eliciting the views of other gynæcologists of larger experience on a subject always of practical importance, but which, owing to the recent strenuous advocacy

of abdominal section in such cases, is of special interest at the present time.

In considering the treatment of uterine fibromata, it should not be lost sight of that every growth of this kind is primarily an interstitial myoma, which in the course of time becomes more or less fibrous in structure by the development of its connective tissue, and which may eventually be either subperitoneal or submucous. Hence the operative treatment required in those cases in which any surgical interference is necessary should be mainly determined by the size and position of the neoplasm, rendering removal either per vaginam or by abdominal section most feasible. According to my own experience the former is more generally possible, even in the case of interstitial fibroids, than is conceded. At the same time, being a believer in the advantages of hysterectomy and oöphorectomy by abdominal section for fibromata, otherwise beyond the reach of gynæcological assistance, I am desirous to obtain some authoritative expression of opinion as to the limitations which should be imposed on these procedures. For if the operative zeal now evinced in the performance of abdominal sections by some eminent surgeons be allowed to develop much further without protest, the legitimate employment of these procedures will be largely prejudiced by the inevitable reaction of opinion against such operations. It seems to be entirely ignored by some of those who urge the early and general performance of abdominal operations for fibromata, that in the majority of cases these tumours may be as effectually dealt with by less hazardous procedures, and that in very many instances they demand no operative interference whatever.

As to the possibility of the spontaneous cure of fibromata by absorption and their occasional diminution under medical treatment, there can be no question. I have myself elsewhere recorded cases in which such tumours had been thus notably reduced in size, and many well-authenticated instances of their complete subsidence in this way have been related.

Amongst these a very remarkable case has been narrated

by my friend Dr. Kidd ('Dublin Obstetrical Transactions,' vol. i. p. 131), in which a large uterine fibroid, that at one time occupied the whole of the upper part of the pelvis and rose in the abdomen midway between the umbilicus and xiphoid cartilage, was within a few years so completely removed by absorption as to leave no trace whatever of its former existence.

The probability of such a termination in any individual instance is, however, too remote to have any material influence on the general prognosis and treatment of such cases. Still, its possibility is a fact which must not be altogether lost sight of.

We may now briefly consider the advisability of abdominal operations in cases of fibromata. Secondly, I shall say a few words with regard to the less heroic measures, such as enucleation and 'removal by traction,' which may, in many instances, be resorted to in place of the bolder operation just mentioned. And, lastly, I shall allude to the too generally neglected medical treatment of such cases. With regard to the first of these methods, I may here recapitulate briefly some yet unpublished observations I have recently made on this subject.

The cases of fibromata requiring either hysterectomy or oöphorectomy under my own observation in the course of a gynæcological experience of upwards of fifteen years in the two hospitals with which I have been connected have been, comparatively, few and far between. Hence I cannot but think that the enormous proportion of such cases met with in the practice of other surgeons must, in some degree at least, be the self-created result of the preconceived views of those who now find these operations so generally necessary, and may be traceable to the analogy instituted between uterine and ovarian tumours. The successful results of the removal of the latter have, however, no bearing on the question of abdominal operations in the treatment of the former. Not alone are the risks of the one infinitely greater than those of the other, but even if they were equal the

conditions for which they are resorted to are so essentially dissimilar, that there can be no parity in their treatment. Ovarian tumours, if left to nature, are, as a rule, rapidly progressive in their course, and ultimately eventuate fatally. Not so uterine fibromata, which, however much discomfort, suffering, hæmorrhagic discharge, and impairment of health they may occasion, never directly destroy life, and in the majority of cases become arrested in their development and symptoms by the changes consequent on the meno-pause. Therefore the amount of risk justifiable in the removal of an ovarian growth is not necessarily justifiable in the case of a uterine neoplasm.

In my own practice I have never hesitated to recommend oöphorectomy, or hysterectomy if required, in cases of subperitoneal and deep-seated interstitial fibromata, in which the tumour was not accessible per vaginam, and in which the age and condition of the patient, the rapid rate of development of the neoplasm, or the urgency of the resulting symptoms, were such as to preclude the hope that in the course of time the disease might be arrested by the occurrence of the menopause. Moreover, in the case of a young woman of the class generally met with in hospital practice, to whom the suffering and loss of physical strength consequent on such a tumour would entail privation of the patient's means of living; if she be willing to encounter the risk of an abdominal section, we are, I think, if the case be otherwise suitable for the operation, bound to afford her the chance of its successful performance.

The advocates of oöphorectomy and hysterectomy apparently take a much larger view of the utility of these operations. For instance, in Mr. Lawson Tait's recent 'Address on One Thousand Abdominal Sections,' as published in the 'British Medical Journal' and in the 'Medical Press and Circular,' are included the removal of the uterine appendages for myoma in 99 instances, with 7 deaths; hysterectomy in 54 cases, with 19 deaths; and one enucleation of a myoma, which proved fatal. Thus we have in all 127 completed abdominal operations bearing immediately on

our present subject. From the same statistics it may be gathered that Mr. Tait has, moreover, had no less than 30 incomplete operations of this kind, 17 of which were in cases of uterine, or unspecified but non-ovarian tumours, in which, after the opening of the abdominal cavity, further procedure had to be abandoned. Of these incompleted operations, Mr. Lawson Tait thinks that he 'may speak with a certain amount of satisfaction,' though from what he derives this contentment I am at a loss to understand, as his mortality in them was 50 per cent. 'This mortality,' he observes, 'is of course heavy, and the results in the great majority of those who survived the operation were very unsatisfactory, though in some the disease has been arrested apparently for an indefinite time. I have no doubt now that in many of those cases I might have finished the operation, in fact I know I could, but I always had a horror of a patient dying on the operating-table, and from that distressing incident I have hitherto been entirely free. I now think that it would have been better even to have had such a disaster, and to have finished a large number of these operations.'

The journal from which I have just quoted contains other evidence of the spreading *cacoëthes operandi* prevalent among abdominal sectionists. Thus Dr. Savage, in reporting upwards of a hundred cases of abdominal section undertaken within a year, states that he performs this operation in every case which he has 'the opportunity of operating on,' without 'the slightest attempt at the selection of cases, and as choosing the most suitable and rejecting those which did not seem to promise to be successful.' Nor does he hesitate to admit that, had there been such selection of cases, he would have had fewer deaths of patients on whom he 'operated with the idea of giving them the slight chance of life the operation afforded, knowing well beforehand how slight that chance was.'

Dr. Keith has recently recorded 38 cases of hysterectomy with only 3 deaths. In the 'American Journal of Obstetrics' Dr. Bigelow has, with great research, collected from all available sources 359 similar operations, of which 227 resulted success-

fully, whilst 132 patients died. With regard to this admitted mortality, greater than one in every three operated on, we may well ask ourselves the question, which was suggested to Dr. Keith by his own more successful practice, viz.: 'Does a mortality of 8 per cent. justify an operation for a disease that, as a rule, has only a limited active life, that torments simply, and that only for a time, though of itself it rarely kills? The mortality of an ordinary uterine fibroid, if left alone, is nothing approaching a death rate of 8 per cent. Most of the cases on which I have operated were known to me for years before; only the extreme cases were done; in nearly all the lives were useless, and the risk of operation was clearly understood. Considering the nature of the cases, it seems to me that these operations were perhaps justifiable; and, if these were barely justifiable, what can be said of those ghastly lists of hysterectomy where the mortality is one death in every two, one death in every three, or even one death in every five?'

Myotomy.—According to Professor Schroeder, any uterine fibromyoma, however extensive, may be removed by laparotomy or partial hysterectomy with the aid of the elastic ligature. The appalling mortality resulting from this operation should, however, I think, sufficiently prevent its repetition by other surgeons. Of those on whom Schroeder thus operated he lost in his first series of cases 30 per cent., and in his second series 22 per cent. of his patients.

Oöphorectomy.—The removal of the uterine appendages, as originally suggested by Blundell, and reintroduced into modern practice by Dr. Batty, of Georgia, whose name, as well as those of Dr. Goodell, of Philadelphia, and Mr. Knowsley Thornton, is now identified with this operation, has been largely employed within the past few years for arresting the development of fibromata, and for the prevention of uterine hæmorrhage consequent on their existence.

Before we can accept oöphorectomy as the panacea that it is claimed to be for uterine fibromata, it seems to me that further proof is needed that it is generally necessary, or feasible in such cases. It would certainly be desirable to

formulate, more distinctly than has been yet done, the cases of fibromyomata in which oöphorectomy may be resorted to with a fair prospect of benefit, and to point out those in which no reasonable anticipation of success can be held out from its performance. In the first category should be placed all actively increasing fibromata not removable per vias naturales, and more especially those occurring in young patients in whom the prospect of reaching the period when any arrest of the tumour by the natural meno-pause might be hoped for is remote, and who, if they survive till then, are meanwhile necessarily condemned to lives of useless suffering. Under these circumstances there can be little question of the propriety of attempting by oöphorectomy to anticipate the distant meno-pause in any case in which this is feasible. But the removal of the ovaries merely for the arrest of hæmorrhage consequent on fibromata appears to me unjustifiable until other and safer methods of checking metrorrhagia have been fully and unsuccessfully employed. And I am convinced by experience that if we try these fairly we shall seldom find it impossible to arrest effectually and safely any uterine hæmorrhage thus caused without oöphorectomy. Secondly, I cannot think this operation generally advisable in the case of quiescent fibroids largely occupying the abdominal cavity in older patients. In such cases the removal of the uterine appendages is generally not merely difficult and hazardous, but even quite impossible in the instances in which, if practicable, it might be most useful. Thus in any large subperitoneal or interstitial fibroid lifting the uterus far above the pelvic cavity, and binding it to the adjoining parts by consequent inflammatory intraperitoneal adhesions, it will be found utterly impossible to reach the ovaries by any abdominal section until the uterus, by which they are overlaid and concealed, is first detached from these adhesions and turned out of the abdominal cavity. In such a case, and it is no ideal one, having subjected our patient to all the risks of such an operation, are we to dissect out the uterine appendages and then replace the uterus and tumour *in situ*? or, in the words of an

eminent American gynæcologist, Dr. Drysdell, of New York, would it not 'be better practice to leave the uterine appendages untouched and remove the tumour itself?'

The removal of the uterus or of its appendages must be regarded as capital operations. And though these are now apparently approached by some surgeons as a matter of routine practice, and with much the same lightness of heart as was manifested by the French Minister when embarking on the Franco-Prussian war, I confess I cannot share this view. In my student days I was taught that capital operations were justified only as means of saving life or relieving suffering otherwise hopeless. It would now, however, appear that the gravest operations may be resorted to in every case in which the opportunity presents itself. For my own part, I am unable to accept this doctrine, and am still old-fashioned enough to believe that no operation of such gravity as that under consideration should be undertaken save as a matter of necessity, and with a reasonable prospect of a successful result.

I may now here again refer briefly to the alternative operations which, according to my experience, may be substituted for the procedures just discussed. First, then, with regard to *Enucleation.* This operation, although usually restricted to submucous tumours, is, in my opinion, applicable to all fibromyomata, whether submucous or more deeply imbedded in the uterine parenchyma, which, from the position and size of the neoplasm, are accessible and capable of extraction through the vagina. If this view be accepted, it would obviously provide an alternative and, as I believe, a safer operation in some of the cases in which hysterectomy and other intraperitoneal operations are now advocated. Every myoma is, primarily at least, histologically undistinguishable from the uterine structure in which it originates, and is only converted into a fibromyoma or fibroid by the gradual development of its connective or fibrous tissue. Before this process is accomplished—and we are seldom consulted sooner—the tumour also, as a general rule (to which,

however, there are many exceptions), becomes encapsuled, or distinctly separated by an intervening layer of cellular tissue from the uterine parenchyma in which, as already said, it originated, and from which, however deeply imbedded, it can in most cases be shelled out and removed, or enucleated.

For this purpose, as for écrasement, the cervical canal must be previously dilated, the patient placed in a semi-prone lateral position and etherised. Next, the uterus should be washed out with a warm carbolised solution, so as to diminish its vascularity as well as to render it as far aseptic as possible. Then a free incision may be made through the endo-uterine mucous membrane and capsule into the most prominent part of the tumour. This is now seized with a strong vulsellum, by which firm traction is made downwards in the direction of the pelvic outlet, whilst, at the same time, with the operator's finger, or where this cannot reach then with either a curved silver spatula or with Thomas's spoon forceps, all adhesions around the tumour are broken up. Lastly, the fibroid, by traction with the vulsellum from below, aided by firm pressure from above, is forced out of its bed and extracted either with the forceps or by splitting into sections that may readily pass through the vulvar outlet. By this operation I have removed not only large submucous fibromyomas but also interstitial, or in some instances partially subserous, tumours. As, however, the feasibility of this procedure in the treatment of any deep-seated mural or partially subperitoneal fibroid is not generally recognised, I may here repeat a couple of instances of this kind in proof of the occasional curability of such cases even without either abdominal section or vaginal hysterectomy.

CASE I.—*Intramural Fibromyoma removed by Enucleation.*

L. B., an anæmic-looking woman, aged thirty-eight, unmarried, suffering from metrorrhagia, pelvic pain, and hæmorrhage, was admitted to St. Elizabeth's ward. Until two years

previously she had been in good health. She then commenced to suffer from menorrhagia, which gradually increased, and the intervals between the recurrence of the discharge became so diminished that for the past year she has seldom been a week free from hæmorrhage. On examination the uterus was found retroverted by a tumour in the posterior wall, and the uterine cavity greatly elongated. The cervical canal was dilated by laminaria bougies, on the removal of which she was etherised, and a submucous tumour discovered occupying the posterior wall from the fundus to near the cervix, and bulging out into the uterine cavity. A free longitudinal incision was made through the thinned muscular structure into the capsule of the tumour, which was firmly seized with a strong vulsellum and drawn down by Dr. Kennedy towards the outlet, whilst with my finger I rapidly separated the loose adhesions around and behind the tumour. This was now forced out of its bed and extracted per vaginam. Immediately afterwards a hot carbolised water injection was thrown up to arrest the free oozing, a tampon of Lawson's cotton saturated in carbolised glycerine was introduced, and an anodyne suppository placed in the rectum. The hot water injection was continued twice daily for the next ten days, at the end of which the uterus, being still large, was brushed out at intervals with tincture of iodine until it had nearly regained its normal size, and three weeks after the operation she was enabled to leave the hospital.

Case II.

An unmarried woman, aged thirty-eight, who, until the day of her reception into the hospital, had been able to follow her avocation as cook in a large hotel, was admitted under my care. For the preceding two years she had been complaining of continual pain in the back, and sense of pelvic weight, debility, leucorrhœa, and slight menorrhagia. These symptoms had gradually increased, but at no time was the menorrhagia very urgent, the changes merely lasting five or six days, and returning every three weeks; nor was there any hæmorrhagic

discharge in the interval. On admission her chief suffering was from distressing dysuria—so great that she had been obliged for some time to visit a medical practitioner every day to have a catheter passed. She also suffered from frequently-repeated and generally futile calls to defecation. She had in addition to tenesmus slight prolapsus ani. Her feet and legs were œdematous, and she complained of great pain along the course of left sciatic nerve.

The vagina was small and the hymen unruptured. On recto-vaginal examination the uterus was apparently completely retroflexed, the hollow of the sacrum being occupied by a large globular tumour extending up as high as the finger could reach, and pressing downwards into Douglas's space. On examination with the sound, which passed in upwards of six inches anteriorly, it was evident that the double compression of the rectum and neck of the bladder was caused by a uterine tumour. To discover the position of this growth the cervix was packed with five sea-tangle tents. On the removal of these next morning the uterine cavity was fully laid open, and as the tumour was interstitial, it was necessary to dissect it out from the posterior wall, in which it was situated, and where it had developed outwards, so as to have become in great measure subperitoneal, the posterior surface of the growth being merely covered by a thin capsule of the uterine structure. In the separation of the tumour, which was as large as the fœtal head at the seventh month, the cervical tissue, which had become disorganised by the pressure of the morbid growth, and was, as usual in such cases, extremely soft and friable, was unavoidably lacerated. This rent extended downwards and backwards through the outstretched roof of the posterior vaginal *cul-de-sac*, and left a wide opening into the abdominal cavity. As soon as the tumour was extricated by the midwifery forceps, a large coil of intestines came down, filling the vagina. These were immediately returned, and the patient being then in such a condition of collapse that no attempt could be made to close the laceration by sutures, it was

merely plugged with a large sponge, so as to prevent for the moment any further prolapse of the intestines. A drachm of ether was injected hypodermically, and a little brandy and tincture of opium thrown into the rectum. Her pulse, which had been almost imperceptible, became a little stronger, and she was removed to bed and there surrounded with hot jars, &c., with the faintest hope of reaction. This, however, took place, and a couple of hours later her pulse was fairly recognisable, and her aspect improved.

On the second day severe metro-peritonitis set in, and for seven or eight days afterwards her life hung in the balance. It is needless here to dwell on the treatment pursued, which consisted mainly of opium and small doses of mercury, hydrocyanic acid draughts, &c., with the usual local applications—namely, leeching on two occasions, and continual use of fomentations or anodyne poultices to the abdomen, together with warm antiseptic vaginal injections. The vagina was plugged with sponges wrung out of weak carbolic solution. The daily changes of these were effected under carbolic spray, an atmosphere of which was maintained about her. For some days she suffered from incessant retching and hiccough, which were controlled by hydrocyanic acid and ice. By the mouth she was only allowed iced champagne in very homœopathic doses, her nourishment for ten days being enemata of beef extract with a little brandy and arrowroot. It is unnecessary to follow the daily notes of the case further than to say that after the subsidence of the peritonitis, from which she was not free for many days, it was found requisite to continue the vaginal plugging for another week, when sufficient adhesion was formed to allow its discontinuance. After the operation her bowels were kept confined for as long as possible. At the end of three weeks she was able to sit up, and a week later was sent to the Convalescent Home at Stillorgan, whence she returned to her former occupation, and is now again employed at the hotel from which she was sent to the hospital.

It is hardly necessary to observe that the enucleation of

any fibroid, especially of one deeply intramural, is never devoid of considerable danger. But this danger is, we believe, generally less than that of any other of the operations which are sanctioned for the same purpose. The risks of enucleation are, firstly, that, as happened in the case referred to, the tumour may have so thinned out the uterine wall behind it that this may be ruptured during the operation and thus probably cause immediate death from shock or hæmorrhage, or subsequently from metro-peritonitis or septicæmia. Even where the integrity of the uterine wall was not affected, I have seen death from the latter cause follow the enucleation of a large fibroid.

Hence, it would be impossible to lay too much stress on the necessity of strict antisepsis, not only during the operation itself, which should always be Listerian, but also in the after treatment by carbolised injections, &c., until the uterine wound has become sealed. Nor, in my opinion, should the operation be ever undertaken by any surgeon who does not believe in the efficacy of the antiseptic system, and who has not time and patience for personally carrying out the subsequent treatment of the wounded uterus in accordance therewith.

Removal by Traction.—In the case of those deeply imbedded myomas which are not encapsuled, we may, in some instances, succeed in their removal by the operation which has been recommended by Dr. Emmet for this purpose. The object of Dr. Emmet's operation, which he terms 'removal by traction,' is the immediate conversion of the tumour by tractile force from an intramural or sessile into an intra-uterine pedunculated or polypoidal form by the method exemplified in the following case.

CASE III.—*Interstitial Myoma removed by Emmet's Operation.*

In this case the patient was a multipara, aged 42, who had always enjoyed good health until four years before her admission into the hospital. She then began to suffer from

menorrhagia, tenesmus, bladder irritation, and bearing-down sensation, which increased. At last she was forced to give up her occupation as a farmer's servant. On admission the uterus was found completely retroverted, and on endo-uterine exploration a considerable-sized tumour was found bulging out into the uterine cavity. This I attempted to remove by enucleation, but on making an incision for this purpose it became obvious that the tumour was not separated by any capsule from the uterine wall, with which it was continuous. Hence, I resolved on trying to effect its removal, if possible, by Dr. Emmet's traction operation. For this purpose the most prominent portion of the tumour was firmly grasped by a vulsellum and forcibly dragged down through the os as far as possible into the vagina. Here as much of the growth as could be reached was cut away with a strong curved scissors. The resulting hæmorrhage was checked by hot water injections, and the remaining portion of the tumour again similarly treated. In this way we had removed more than two-thirds of the growth, when the patient became so collapsed that I was reluctantly obliged to postpone its complete ablation. A hypodermic injection of ether was administered, and she was put back to bed. For the two days following her condition was apparently satisfactory, her pulse fairly good, and temperature not rising above 100°. On the second night after the operation she again became collapsed, and, despite the efforts made to save her, she sank, and died.

In discussing the surgical treatment of fibromata I have confined myself to abdominal operations and their alternatives, and hence I have not here alluded to the treatment of polypoidal submucous tumours by écrasement, &c.

Medical Treatment of Myomata.—With reference to the medical treatment of uterine tumours a few words may be added, chiefly applicable to the cases of non-encapsuled myomatous growths, in which alone medical treatment may be expected to be of much utility.

In many instances, especially of submucous myomata, operative interference is not so essential as is generally sup-

posed. In other cases surgical treatment will not be submitted to, or may not be feasible. Under such circumstances we may, as I have learned by experience, sometimes succeed in arresting the progress of the neoplasm, alleviating its symptoms and restoring the patient to comparative health and comfort by purely medical means.

The objects of this treatment are twofold. The first indication is the arrest of that hyperæmic condition which invariably accompanies the development of a fibro-myoma, and by which the vitality of the neoplasm is sustained, and whence originates the consequent uterine hæmorrhage.

The most prominent symptom of fibromata, especially if submucous, and occurring before the meno-pause, being uterine hæmorrhage, the arrest of this must be a primary object of treatment. For this purpose the patient should be kept at perfect rest from the time when the recurrence of the hæmorrhage is expected until the menstrual period has completely passed over. In the way of medicine, sulphuric acid with liquor ergotæ, or Dover's powder and gallic acid, may be given, or hazaline may be tried. In any serious case of hæmorrhage thus caused, however, it will be better at once to resort to the only reliable styptic remedy for such cases, namely, the free hypodermic use of either ergotine, or, preferably, of the ordinary liquor ergotæ. During the past eight years I have employed either liquor ergotæ or ergotine in this way in nearly every case of this kind treated in my gynæcological wards, and I have no hesitation in saying that we may thus control any hæmorrhage, however extensive, caused by uterine fibro-myoma. Moreover, by the continued employment of these hypodermic injections in some instances such a marked diminution in the size of the tumour may be occasioned as to render any further treatment unnecessary.

Amongst the means by which the congestive hypertrophy of the uterus, always attending the development of these fibro-myomas, may be diminished, and the consequent hæmorrhage be lessened or checked, none are so invariably beneficial as the persistent and judicious use of hot-water uterine irrigations

or injections. To be of any use, however, in such cases, the cervical canal must be previously dilated, and the irrigation persistently employed, not only at regular intervals, but also for a lengthened period on each occasion. Our second therapeutic aim in such cases should be so to stimulate the activity of the local absorbents as, if possible, to induce the diminution of the tumour.

Foremost amongst the remedies available for these purposes are iodide of potassium, the bromides of ammonium and potassium, and the small doses of tincture of iodine which I suggested ten years ago in a paper on this subject in the 'Dublin Obstetrical Transactions.' Chloride of calcium, in the form of the old solution of the hydrochlorate of lime of the Dublin Pharmacopœia, from which, in the hands of the late Dr. McClintock, I have seen marked benefit in the treatment of uterine tumours, has again come into favour in such cases, and probably acts by inducing a certain amount of calcification, and consequently diminished vitality in the neoplasm. By far the most useful, however, of all drugs in such cases is iodide of potassium, given in as large doses and for as long a period as it can be safely administered. I have had so many proofs of the diminution in size thus caused in large myomata, in patients of otherwise robust constitution, that I can only account for its failure in the hands of other practitioners from its injudicious administration in the case of patients of broken-down constitution, or in cases otherwise unsuitable, or from the insufficient doses in which it has been given.

Lastly, a word may be added with reference to the benefit derivable in many cases of fibro-myomata from the use of iodated and bromated mineral waters. On this subject I have elsewhere written so fully that I shall merely again reiterate the opinion, founded on my own experience of spas, which has been borrowed by others, and which was gained by extensive personal observation of the effect of the mineral springs of this class in Germany, Switzerland, and France, on patients undergoing 'the course,' as well as in cases in which

I have since then prescribed these waters, viz. that in cases of uterine myomata, in which, for any reason, operative interference is not available, we may possibly succeed in arresting the development of the disease by sending our patient to a suitable iodated or bromated spa such as Kreuznach, Wildegg, or Schinznach.

The PRESIDENT remarked that as the time for the adjournment of the meeting had so nearly arrived he thought it might be well to postpone the discussion upon the paper which had just been read until a subsequent meeting, and as the subject-matter was one of daily increasing importance, upon which, he felt sure, very wide divergencies of opinion existed, he suggested that an entire meeting should be set apart for its consideration. The author of the paper was at the last moment prevented from attending in support of his views, and this was an additional reason for postponing its discussion, especially as he was sure that exception would be taken to many of the statements and opinions contained in the paper.

Mr. LAWSON TAIT quite concurred with the view which the President expressed that it was perfectly impossible to discuss a paper of that kind in a few minutes. For his own part he differed almost entirely with Dr. More Madden in everything he said, and he therefore moved that the discussion of the paper be deferred for a month, and that the meeting at which it took place should be given up entirely to a discussion on the treatment of uterine myoma.

Dr. BANTOCK seconded Mr. Lawson Tait's motion, which was carried.

The Society then adjourned.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, May 13th, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 24 Fellows, 14 Visitors. The following gentlemen were elected Fellows of the Society:—Dr. G. M. Carfrae, Dr. E. R. Evans, Dr. W. L'Heureux Blenkarne, Dr. John Mackie, Dr. A. J. W. Keenan, Surgeon-Major F. H. Hensman, Mr. A. E. Prockter, Dr. L. Fuller, Dr. W. Jaques.

The following gentlemen were proposed for election:—Dr. Milne Murray, Edinburgh; Dr. Hugh Sutherland, London; Dr. T. Wood Hill, London; Dr. W. T. Hudson, London; Dr. John Hackney, Hythe; Dr. F. C. Batchelor, New York; Dr. G. B. Fraser, Weston-super-Mare; Dr. W. J. Arnold, Detroit; Dr. C. E. Steele, Liverpool; Dr. H. J. Stormont, Brighton.

Dr. HEYWOOD SMITH exhibited a multilocular cyst of the left ovary, which he had removed from a patient the same afternoon, together with the right ovary, which also contained a cyst with chocolate-coloured contents, and a small subperitoneal fibroid (size of a small bean) from the same patient. The woman was 30 years of age, had been confined nine months, and had just weaned her infant. The operation presented considerable difficulties, as both ovaries were adherent in their respective cul-de-sacs, and the pedicles were rather friable, and tearing, gave rise to considerable hæmorrhage. This was eventually controlled, and a glass drainage tube inserted. He brought the case forward in order to open the question of menstruation, as the patient had, notwith-

standing the diseased condition of the ovaries, menstruated during the whole time of lactation.

Dr. EDIS thought the case of interest in reference to the question as to whether menstruation was due to the influence of the ovaries, both of them in this instance being diseased. Possibly the right ovary, which was only slightly enlarged, and embedded behind the uterus, may have been the initiating cause of menstruation during lactation; at the same time Mr. Lawson Tait might contend that menstruation could not possibly be due to the ovaries, as both of them were diseased. Dr. Edis would be glad to hear Mr. Tait's views on this subject.

Mr. LAWSON TAIT said that of course it was rather inconvenient and not quite possible to have a discussion upon the ovular theory of menstruation as a sort of by-issue to the paper now before them. It was perfectly clear, from the frequency with which this question turns up, as well as from the immense and fundamental importance which it possesses for all gynæcological work, that it would be one of the most important things the Society could undertake to collect evidence upon which it might be settled; not as individuals, but the Society should do it as a body. It was, to say the least of it, somewhat discreditable that a question which lay so completely at the bottom of all the physiology and pathology of the organs, with which the members of the Society were so prominently concerned, was yet not capable of settlement. One point he must urge again, as he had frequently done in the past, that in order to maintain the ovular theory of menstruation it was necessary to show that the ripening and dehiscence of the Graafian follicles was coincident and concurrent with the process of menstruation. All the evidence in his possession showed that there was no such coincidence and concurrence, and without its complete proof this ovular theory of menstruation must go to the wall. The question, therefore, was really an extremely narrow one, and there were countless methods by which a research might be made. Thus he would point out that in the early stage of phthisis, what had been

called the pre-tubercular stage in women, one of the earliest symptoms was the arrest of menstruation. This arrest of menstruation by no means involved the arrest of ovulation, because in this stage, he was informed, women not unfrequently became pregnant. It would be, therefore, a matter of the greatest importance for physicians attached to special hospitals for consumption to discover in what relation the arrest of menstruation stood in such cases to the process of ovulation, and what parts of the organism were affected in such a way that a change was visible by the ordinary methods of pathological research. He had already drawn the attention of Dr. Douglas Powell to this point.

Dr. BANTOCK referred to the frequent occurrence of pregnancy during suckling and in the absence of menstruation. He had known several cases where women had never menstruated during the period of child-bearing, extending over several years. It was well known that menstruation occurred sometimes even when both the ovaries and tubes were removed, and he had several times observed that when both ovaries were in a state of cystic degeneration menorrhagia and metrorrhagia were present. His own observations had led him to the belief that the only organ essential to menstruation was the uterus itself. He thought the subject was a very suitable one for investigation by the Society.

Dr. BARNES was not yet prepared to accept the views of Mr. Lawson Tait as to the influences of the ovaries and Fallopian tubes. For the present at least he adhered to the old belief that the tube was little more than an oviduct, and that the *primum mobile* of menstruation lay in the ovaries. The uterus was the common seat of the discharge, but *per se* it was not enough for menstruation. It was certain that in the majority of cases menstrual flow did not recur after the removal of the ovaries; and in those cases in which a hæmorrhagic discharge recurred after such removal, this might be explained on the theory of a constitutional habit which had been started originally under ovarian influence. Underlying all was probably a deeper constitutional condition which re-

quired the ovarian stimulus to determine the hæmorrhagic phenomenon. There was no doubt still much to be learnt about menstruation; but, looking as he did with interest to the work of Mr. Tait, he must regard as a heresy his doctrine that the ovaries were of no importance in relation to menstruation.

Dr. AVELING believed the whole of the secondary sexual characteristic phenomena depended on the existence of an ovary. If this was absent in a woman she would not have pubic hair, and the function of nidation would not be established. He agreed with Mr. Tait in believing there was no synchronous coincidence between ovulation and menstruation.

Dr. MEADOWS was of opinion that the Society would be fulfilling a useful function if it were to appoint a small committee to collect evidence and information on the subject of ovulation.

Puerperal Tetanus. By Dr. R. C. BENINGTON.

I WAS called on September 16, 1881, at 7 P.M., to a woman in her second labour, the first having been natural in all respects.

She had been in labour about six hours, and had been under the care of a midwife. She, finding that labour was not progressing, sent for me, stating that 'something had come down.'

On arrival I found the patient had arrived at her full time The os was fully dilated; the membranes had ruptured; the head was in the vagina, and pains coming on with two or three minutes' interval.

There was a thrombus on the left labium about the size of a man's fist.

Finding that the pains had no effect in advancing the labour, I applied Barnes' forceps, but failed to move the head. Dr. Walker, of Peckham Rye, kindly saw the patient with me about 11.30 P.M. Before resorting to craniotomy he desired to try Simpson's forceps, which he was accustomed to use, and with considerable exertion he delivered her. The perinæum was ruptured up to but not through the sphincter

ani. There was considerable hæmorrhage, principally from the seat of the thrombus, which was stopped by swabbing with a solution of perchloride of iron.

The presentation was third cranial, and the child still-born.

Next day the patient passed water easily, temperature 101; third day, bowels open after a dose of castor oil, temperature 99.

From this time until I saw her at noon on the seventh day she appeared to make an exceptionally good recovery.

At my visit on this day I learnt that she had not passed water for twenty-four hours, and although she desired to do so was unable. I passed a catheter, and drew off a pint and a half of healthy-looking urine. During the operation I noticed that the lochia were very offensive, and I ordered the vagina to be syringed out with a weak solution of carbolic acid. This direction was not carried out: temperature 99.

At 7 P.M. the same evening the husband called me in a hurry, saying his wife had lock-jaw. I went immediately, and found her suffering from severe pains in the nape of the neck and about the jaws. There was a slight amount of trismus; temperature 103. She could swallow nothing; a frothy foam issued from her mouth, and the slightest touch about the head, neck, or shoulders caused a paroxysm of pain and feeling of strangulation accompanied by emprosthotonos. The attacks became more frequent and severe, and the trismus more marked as time went on. She sat on a chair, leaning over the back, and supported in her husband's arms. She held the handle of a knife between her teeth to prevent the mouth closing entirely, and refused to alter her position during the whole of the attack.

Her mind was perfectly clear and her senses painfully acute the whole time. She died exactly twenty-four hours from her seizure—'strangulated,' as her friends described it.

I have collected reports of 41 cases more or less fully described. Of these

21 cases occurred after abortion.

17 cases occurred after labour at full term.
4 cases time not mentioned.

Causation:—

In 10 cases hæmorrhage is the only cause assigned, and, out of these 10, 7 were after abortion, and one secondary hæmorrhage three or four weeks after delivery.

Hæmorrhage with some other complication (as placenta previa 1, adherent placenta 2, mental worry 2, pelvic inflammation 1, ruptured perinæum 1) is given in 7 cases.

10 cases no cause is assigned.
14 cases various causes.

Exposure to cold and nervous temperament, out of which 3 recovered.	7 cases,
Retention of placenta or membranes . .	4 „
Laceration	2 „
1 occurring in a woman who had been operated upon for diseased knee-joint two months before delivery, and in whom much hectic fever existed	1 case.

There are four recoveries mentioned, three of which have already been cited.

Duration of the disease appears to be about seven days average.

Date of the onset about the seventh day. In one case symptoms came on on the second day, and in one as late as the sixteenth, the longest being those due to exposure to cold.

Dr. Denham reports in the 'Dublin Quarterly,' 1865, a fatal case in a cow after adherent placenta. It is important, whilst considering the subject of tetanus occurring in women in the puerperal condition, that we should bear in mind the sensitive state of the nervous system, the changes that are taking place in the blood, and the disturbance of the circulation. To enlarge on this portion of the subject would be out of place. I will merely mention that these conditions being present, the state is one of extreme nervous susceptibility predisposing to functional derangements of the nerve

centres, and will call attention to the writings of Trousseau on 'Tetanie,' and the occasional occurrence of convulsive attacks—other than those accompanied by albuminuria and chorea in pregnant women—as showing the liability in this condition to attacks somewhat analogous to but distinct from true tetanus.

In cases of pregnancy when such attacks occur the emptying of the uterus is usually quickly followed by a subsidence of the phenomena, showing plainly that they were caused by persistent irritation of the peripheral nerves reacting on an already over-susceptible nervous system. But the fact of tetanus occurring after the removal of what in other cases has proved to be the source of irritation, makes it probable, I think, that there is some other abnormal condition which is the cause of the disease.

Dr. Wiltshire ('Obstetrical Transactions,' vol. xiii.), in speaking of this subject says, with regard to the effect produced on the system by the retention of a piece of placenta, the foreign body may keep up the tetanic symptoms in two ways :—

1. By virtue of its mere presence.

2. By supplying conditions favourable to the generation of an animal poison possessing effects analogous to those of strychnia.

In many of the detailed cases conditions favouring a toxæmic condition of the blood exist. I think also this view is strengthened by the prevalence, or comparative prevalence, of this disease in hot countries and in badly ventilated lying-in hospitals; also by the date of the onset of the symptoms. If it were due in any way to the debility caused by the hæmorrhage, except by its power of increasing absorption, why should the symptoms not come on till about the seventh day? when the system has had time to recuperate.

If this disease is caused or induced by a toxæmic condition of the blood, it may be asked, why is its occurrence so rare? May not an explanation be found by attributing its occurrence to a more virulent and sudden condition of infection, which at once acts with such force on the ganglionic

centres as to leave no time for the more usual course to take place in which the initial rigor is replaced by tetanic spasm?

The rare occurrence of the disease and its quick termination has hitherto given but little chance for treatment, but in the last case mentioned, reported by Professor Dill, of Belfast ('British Medical Journal,' October 1, 1882), weak antiseptic injections were used in conjunction with other appropriate treatment, and the patient recovered.

	Reporter's name	Source derived	Date of pregnancy	Assigned cause	Date of onset of symptoms	Duration of disease	Termination
1	Pescay	Collongues	Full term	Nervous temperament Exposure to cold	16th day	...	Recovery
2	Aubinais	,,	7 months				
3	Trousseau	,,	Full term	Cold	14th ,,	24 hours	Death
4	Sourdet	,,	...	Partial retention of placenta	9th ,,	...	,,
5	Blacksham	B. M. J., 1865	10 weeks	Hæmorrhage	10th ,,	5 days	,,
6	Denham	Dublin Quarterly, 1865	Abortion	Nervous temperament Hæmorrhage	...	...	,,
7	,,	,,	,,	,,	...	...	,,
8	,,	,,	,,	,,	...	...	,,
9	,,	,,	Full term	,,	...	...	,,
10	Philipson	B. M. J., 1865	,,	Hæmorrhage, shock, and adherent placenta	10th ,,	5 days	,,
11	Simpson	Selected obst. works	3 months	...	7th ,,	3 ,,	,,
12	,,	,,	9 weeks	Hæmorrhage	6th ,,	3 ,,	,,
13	,,	,,	Early preg.	,,	7th ,,	60 hours	,,
14	,, Velpeau	,,	,,	,,	...	...	,,
15	,,	,,	3rd mon.	,, Mental agitation	11th ,,	7 days	,,
16	,,	,,	,,	Hæmorrhage	8th ,,	70 hours	,,
17	,,	,,	Full term	Laceration of perinæum and vagina	72 hours	3 days	,,
18	,,	,,	,,	...	6th day	6 ,,	,,
19	,,	,,	,,	Hæmorrhage 3 or 4 weeks after delivery; retained placenta; offensive discharge	6th ,,	3 ,,	,,
20	,,	,,	,,	,,	7th ,,	1 day	,,
21	Collongues	'On Tetanus after Abortion,' 1878	Abortion				
22	...	B. M. J., Jan. 20, 1883	Full term	Hæmorrhage	11th ,,	9 days	,,
23	Wiltshire	Trans. Obst. Soc. vol. xiii.	Abortion	Bruising of cervix, laceration of os. Mental worry. Piece of pla. adh. to fundus	...	...	,,
24	,,	...	,,	Mental worry	...	...	,,

	Reporter's name	Source derived	Date of pregnancy	Assigned cause	Date of onset of symptoms	Duration of disease	Termination
25	Collongues	...	Criminal	Nervous temperament Laceration of cervix	14th day	...	Death
26	,,	...	Abortion	Hæmorrhage Placenta previa	13th ,,	3 ,,	,,
27	,,	...	,,	Hæmorrhage Pelvic inflammation	11th ,,	3 ,,	,,
28	,,	...	,,	...	9th ,,	6 ,,	,,
29	Simpson	Selected works	Full term	Exposure to cold	4th ,,	7 ,,	,,
30	,,	,,	,,	Suppression of lochia ,,	4th ,,	10 ,,	,, Recovery
31	,,	,,	7 months	Eclampsia during pregnancy. Exposure to cold.	5th ,,	24 ,,	,,
32	,,	,,	Full term	Exposure to cold	14th ,,	1 day	Death
33	,,	,,	,,	,,	2nd ,,	...	,,
34	,,	,,	,,	Hæm. turning, adh. placenta, rigors and sweating 4th and 5th days	5th ,,	A few hours	,,
35	,,	,,	,,	Operation for diseased knee-joint 2 months before. Much hectic fever	...	...	,,
36	,,	,,	Early preg.	...	14th day	4 days	,,
37	Benington	...	Full term	Hæm., rup. perinæum	7th ,,	24 hours	,,
38	Dill	B. M. J., Oct. 7, 1883	3 months	Hæmorrhage	11th ,,	72 days	Recovery

39 The late Dr. Merriman: 10,190 patients, 107 deaths, 1 lock-jaw.
40 Fourth annual report Registrar-General: 116 deaths from tetanus, 96 males, 20 females, 2 after parturition.
41 Dr. Denham, 'Dublin Quarterly,' 1865: 232 fatal cases after parturient in Bombay. Dr. Denham also reports the instance of a cow dying of tetanus after adherent placenta.

Dr. BANTOCK stated that he had had one case of tetanus after ovariotomy. The patient was a young subject, aged 24, and not addicted to the vice of which the president had spoken. The pedicle of the tumour was twisted into a cord, and the tumour had contracted adhesions to the broad ligament. The patient made a very satisfactory convalescence till the morning of the tenth day, when she first complained of stiffness in the left side of the face. On his return from the country he found her next day the subject of violent tetanic spasms, and she died a few hours afterwards. Mr Doran made a very careful examination of the stump of the pedicle and adjacent parts, but could find nothing to account for the tetanus, all the parts being in the most healthy state.

Examination of the spinal cord revealed the existence of inflammatory action. The only explanation that could be suggested was an exposure to a draught, and it is rather corroborative of this that the symptoms first began in the side of the face exposed to a current of air which caught the patient as she lay between a window and the fireplace. The weather at the time was exceedingly cold, with hard frost and heavy snowfall, in the end of November 1879.

Dr. BARNES observed that the case related by Dr. Benington was of extreme interest, as illustrating a disease rare in this country. There was something in the constitution of pregnant women that seemed to predispose in an especial manner to tetanus. The exalted vascular and nervous tension rendered the gravida peculiarly susceptible to convulsive disease. This high tension dropped on delivery; but still the tetanus more often broke out after labour. How is this explained? In the first place he would ask—is there such a thing as 'idiopathic tetanus'? or is this term simply an *asylum ignorantiæ*? He believed a close analysis of cases would show that there are always three factors, at least, in operation. First, there is a peculiar state of nervous susceptibility; secondly, there is a poison-element; then there is the *tertium quid*, the exciting cause, which is commonly a wound. Thus we may admit the hypotheses of epidemic influence and of traumatism. A peculiar poison in the blood which chemists had hitherto failed to identify in all probability was concerned. This was consistent with Mr. Lawson Tait's hypothesis of epidemic influence, and also with the statement of Dr. Wiltshire that in cases in which tetanus occurred after abortion something was retained in the uterus.

This view was further strengthened by the striking analogy between strychnism and tetanus. He had assisted Marshall Hall in some of his experiments on strychnism which were full of interest in their application to this problem. Having removed the brain of a frog, a minute quantity of strychnine was injected under the skin. Now, if the animal were kept perfectly at rest, tetanus might not set in; but

instantly on pricking or pinching the skin, or even shaking the table, violent convulsions ensued. Here, then, we have the poison and the traumatism; neither of itself would bring out the tetanus. So in the puerperal process we may find the poison, and in the labour the traumatic excitant. The treatment was a point on which he felt it desirable to insist. He had had under his care a severe case of poisoning by strychnia, marked by intense opisthotonos and trismus; the attacks were excited by touching the patient and by his efforts to speak. Watching keenly for the earliest indication of an attack, the man was made to inhale nitrite of amyl; the attack was always resolved. This plan was kept up all night, and after twenty hours the danger was over. Dr. Barnes was persuaded that tetanus and strychnism killed by the repeated shocks or blows dealt upon the nervous centres, and that if these shocks can be averted recovery may occur, by the elimination of the poison and the subsidence of the extreme irritability of the nervous centres.

Dr. EDIS alluded to a paper by Mr. Hutchinson, reported in the eighteenth volume of the 'Obstetrical Transactions,' in which the author gave details of several cases of tetanus occurring in ewes after parturition, opium acting like a charm in curing the condition. Trismus nascentium in infants was a not uncommon condition in lying-in hospitals in years gone by, due in many instances to exposure to cold and unhygienic surroundings.

Dr. ROUTH said that it was scarcely right to say that these recurring cases were evidence of epidemic influences. Everybody knew that bad cases often occurred together, such as placenta previa, and yet no epidemic influence could be present there.

Dr. BENINGTON, in reply, said he was afraid his paper had not altogether succeeded in elucidating the point he was most anxious to emphasise; this was, that in the large majority of cases it might fairly be assumed that some fœtal débris was left behind in the uterus. This would favour the assumption that an active factor in the genesis of the disease was the absorption of poisonous matters.

Double Uterus.—Pregnancy in the left half, hæmatometra in the right. By LAWSON TAIT, *F.R.C.S.*

M. A. G., aged 39, the mother of twelve children, applied as an out-patient at the hospital on November 20. She was a tall, largely-made woman, with a perfectly healthy appearance, and stated that she had been confined that day three weeks, but still remained a very large size. On examination, a very large cystic tumour, perfectly loose, was found to occupy the abdomen. At first I was disposed to regard it as an instance of parovarian tumour growing with great rapidity after labour, having met with a number of similar cases. On handling the tumour, however, it became tense in exactly the same way that the pregnant uterus does during the rhythmic contractions, and, on making an examination of the pelvis, a protrusion of the size of the normal cervix was met with on the right side of the vagina, but no aperture in it could be discovered. Higher up the vagina a cervix and os could also be made out, and bi-manual examination made it perfectly certain that the second organ was that from which the child had passed, and that the tumour and the first cervix together constituted the right half of a double uterus. Stethoscopic examination gave perfectly negative results, but I believed it quite possible that I had to deal with a case of pregnancy of the second uterus. The patient was admitted to the hospital, and in a day or two was put under chloroform. I passed my finger into the vagina and perforated the nipple-shaped prominence of the first cervix, and scratched it through with the finger nail. The result was the immediate flow of a large quantity of bloody serum and pieces of clot. The aperture was enlarged by steady pressure of the finger, and a very large quantity of clot was removed, the uterus steadily contracting during the process. Finally the cavity was thoroughly washed out with warm water. The patient made an uninterrupted recovery, leaving the hospital on the fourteenth day, and when seen on January 5 the supplementary uterus was contracted to the size of a cricket ball, and could just be felt

above the brim of the pelvis, whilst its cervix in the vagina had almost entirely disappeared.

Dr. ROUTH said that cases of double uterus were much more common than generally believed, but were very often overlooked. He remembered a case where Dr. Greenhaigh had shown there were two vaginas and two uteri, one in use, but not the other, because the two vaginal walls were closely applied to each other. He (Dr. Routh) had not detected this, he mentioned, lest he should appear to arrogate to himself more skill than his compeers. In several cases his suspicions had been aroused by finding that on passing the sound one day he could diagnose a much anteverted uterus, and the next day a much retroverted uterus, and yet in each case there appeared to be enlargement above and below the common os. The use of two sounds cleared the diagnosis, one passing upwards and the other downwards, and because it was impossible to make or feel the ends of the two sounds touching one another. Sometimes the sounds passed in, one on each side of, instead of above and below, the common os.

Dr. J. MANSELL-MOULLIN asked Mr. Lawson Tait if he felt perfectly confident of the rhythmical contraction of the tumour. The usual condition in passive distension of the uterus was a thinning and atrophy of the muscular walls of the uterus. He further inquired if there were any history of urgent dysmenorrhœa, seeing that the hæmatometra was of antecedent date to the pregnancy.

Dr. HEYWOOD SMITH said that a few years ago he had under his care at the Hospital for Women a case of complete double uterus and vagina, where the cervices were separate, the bodies of the uteri of normal length, the fundi divaricating from each other into two horns. The vaginæ were also quite distinct, the intervaginal septum reaching quite down to the vulval orifice.

Mr. LAWSON TAIT, in reply to the questions concerning the case, was unable to give any further account, because the woman had a very limited amount of intelligence and could

not give any accurate history. All that was known was that after her delivery she did not diminish in size, as she had previously done. The tumour was subsequently discovered as narrated. Mr. Tait, of course, expected to find in the second uterus something like a fœtation, but the most careful research amongst the débris by himself and his assistants failed to find the slightest indication of pregnancy in the second uterus. That cases of double uterus were very much more frequent than was generally imagined his own experience led him to believe, and he was glad to find that Dr. Routh was of a similar opinion.

Gynæcological Surgery. By HORATIO R. BIGELOW, M.D., Permanent Member of the American Medical Association.

I trust that the members of the British Gynæcological Society will pardon me if I take as a text for my brief paper the salient features of a private letter which Dr. Bantock has done me the honour to write to me. Permanent and valuable surgical advance must come from the dispassionate discussion of vital principles, emanating from those who have the right to be heard. If you will allow me then to go over a somewhat well-trodden field, I will touch upon: 1, The vaginal extirpation of the cancerous uterus; 2, Laparotomy for myofibromata; 3, Listerism. 1. Dr. Bantock writes: 'Extirpation of the uterus for malignant disease is likely to die out in this country. It is very rare to find a case at a sufficiently early period, and a belief is gaining ground here that where the patient has been alive three or four years after the operation, the disease was not cancer at all.' During the last three years Dr. A. Martin, of Berlin, has extirpated the cancerous uterus sixty times with five deaths, and these happened during the early stages of the operation when perfect technique had not grown out of a ripe experience. From the commencement of his operative interference in these cases he has made the extirpation over one hundred times. The histories in these instances show that the patients went two, four, six

years, and even more, without a recurrence of the complaint.[1] Germany's place in pathological investigation is such a pre-eminently high one that one can hardly suppose that all of these cases were *wrongly* diagnosed. In no other country is pathology so well taught, in no other country is an acquaintance with pathological processes so general, and in no other country does this science constitute so large a part of the student's curriculum. Were a recognised German authority to pronounce an opinion in pathological research which should be disputed by other *savants*, I do not know to what court they could submit the question for harmonious adjustment. It cannot be maintained with reason that men like Schroeder and Martin would make mistakes of this kind in *every* (?) instance. This objection may be left out of the question. It may be urged that the operation does not extend the life of the patient, that it subjects her to a certain risk without accomplishing anything. It is not within the pale of a limited, finite, human judgment to predict how long anyone's life may have been had she not been operated on. But even should it be granted that the life was not prolonged, the few months or years that are left to her are months or years of comparative freedom from suffering and of mental quietude. Hope buoys up the frame that was wretched from the knowledge that it was carrying about a malignant disease, the very name of which makes one tremble. And even had the operation accomplished nothing more than a rehabilitation of the shattered nervous system, it had done vastly more than an expectant plan of treatment. What is the risk? Scarcely greater to-day in the hands of gynæcologists here in Berlin than that of an ordinary ovariotomy—and yet who hesitates to do the latter? Thirty successive cases of vaginal extirpation without a fatal result may well strip this procedure of any terrible apprehension. Thirty successive cases in which the patients have had comfortable lives for variable lengths of time, which conditions could not possibly obtain under any other known

[1] See Düvelius, 'Beitrag zur Lehre von der vaginalen Exstirpation des Uterus.' *Deutsche Med. Woch.*, No. 9, 1885.

plan, go far to place the operation upon a solid foundation. Thirty successive cases in which the disease did not appear for some time, in some instances not appearing up to the date of this communication, ought to show that the operation is not only a justifiable one, but one which the intelligent surgeon is called upon to perform when a patient's life hangs in the balance.

What are its difficulties? As done by Martin, the only difficulties are those which all disappear with the greater dexterity in the operator. What I may term the intrinsic difficulties are met with *only* when the uterus is extremely friable, and cannot be pulled through the posterior incision without breaking down, or when the deep pelvic adhesions are diffuse and intimate. The bleeding *ought* to be slight, since everything is secured as the cutting goes on, and since all bleeding points can be made out very readily. The hardest part of the operation is in catching hold of the broad ligament and adjusting the sutures. The argument—so it seems to me—cannot possibly hold, which would contra-indicate the operation in all cases where the cancer had been diagnosticated beyond a question of reasonable doubt, upon the ground that the disease would reappear. If such a policy should govern surgery, no malignant growth in any part of the body could be treated by extirpation, and no disease which had implicated the lymphatic system could hope for anything of benefit at the hands of a physician. If, then, a case be diagnosed as malignant by a competent authority, if statistics of operations show that the rate of mortality is extremely favourable to the patient, and if life histories subsequent to such interference show freedom from suffering for a length of time, what rational objection is there to vaginal extirpation? Must this surgical advance be forced to drag its way to the light of general recognition through the same nasty slough of despond which soiled the skirts in earlier days of other operations which we believe now have conferred such boons upon humanity? I hope not.

2. Laparotomy, with special relation to the treatment of

the pedicle.[1] Dr. Bantock writes: 'With regard to hysterectomy I still prefer the *extra-peritoneal* plan.' He gives his own statistics, which much favour such a conclusion, and adds, 'It cannot be denied that so far the best results have been obtained with the extra-peritoneal method. This is the experience of Keith, Hegal, Tait, and myself. Still the question is an open one, and I should be glad if a satisfactory method of intra-peritoneal treatment could be found to ensure better results than the extra-peritoneal has hitherto yielded.' Martin's statistics (not including ovariotomies, of which he has done 105 during the last year, with *four* deaths—only *one* being from sepsis) are as follows: Of 32 laparotomies *without* prophylactic drainage there was a mortality of 34 per cent. of which 21·9 per cent. died of sepsis; of 33 laparotomies with prophylactic drainage there was a mortality of 24 per cent., of which 12 per cent. died of sepsis. Since this publication I have seen him do eight laparotomies with drainage, all of which have recovered. Schroeder's statistics are all given by Hofmeier, since which time he has of course done many more, and his results grow better and better. All of these operations, as indeed all that I have seen in Berlin, are intra-peritoneal. Up to 1883 Kaltenbach had done 10 operations with one death. Keith, to December 1883, had done 25 with two deaths. The results of other operators are reproduced by Hofmeier, from my papers on this subject in the 'American Journal of Obstetrics.' Bantock's results to March 1883 were 22 cases and two deaths. Tait's to September 1882 were 30 cases and 10 deaths. The results attained by Hegar, Bantock, and Keith in the extra-peritoneal plan are beyond all cavil. These operators have cut down the death rate to a minimum, and their work is a matter of record. Péan's results are not as good. The number of cases treated extra-peritoneally of which we have the literature is not as large as those reported to be intra-peritoneal; and the material, I imagine, at the disposal of those who adopt the external plan is not as large

[1] See Hofmeier, 'Die Myomotomie,' &c., and A. Martin, 'Ueber die Stielversorgung nach Myomoperationen.' (*Berl. Klin. Woch.* 1885. No. 3.)

as one sees in the hospitals here in Berlin, where the internal plan is exclusively followed.

It is hard, therefore, to draw any very logical conclusions from statistics alone, as I have elsewhere written, for purposes of surgical neatness, and as the outcome of sound surgical reasoning. I am drawn strongly to the intra-peritoneal. I have personally seen very many cases of it. The operation is rapidly done, there is *never* any subsequent hæmorrhage, and the only danger to guard against is that of *sepsis*. This is, of course, always a matter of apprehension, but where the flaps are properly prepared and sewn over, and where drainage is used (through the vagina), even this fell attendant is losing power. I have seen every variety of stump, but I have never yet seen a case of secondary hæmorrhage. The stump can be temporarily secured by the elastic ligature. Then a stump needle can be passed through just above the elastic, double threaded, and one half the pedicle tied. Then double thread again, withdraw the needle, and tie the other half. Then excise the superabundant tissue in the centre of the stump, touch with the cautery, and afterwards with 10 per cent. carbolic acid, and unite the flaps over the pedicle with the continuous or interrupted suture, or sew through and through with the cobbler's stitching. If such a plan is carried out, there will never be any oozing from the stump. This certainly is a pretty operation, a clean one, a rapid one, and a perfectly safe one the danger of sepsis once being conquered. Martin drains posteriorly through the vagina, and his results by this plan are getting better all the time, although some of the cases that I have seen have been *exceedingly* unfavourable ones. I do not just now remember in how far soever the plan has found favour of reopening the abdomen when the earliest symptoms of sepsis have been made out, but it occurs to me that the condition justifies the experiment. It it be urged that the system has already so appreciated the local contamination that nothing will be of avail, then I would answer that any treatment addressed to erysipelas or to puerperal septicæmia, in which stress is laid upon the anti-

septic local disinfection, would be equally useless. We know that uterine irrigation of an antiseptic fluid has answered an admirable purpose in some cases of so-called puerperal fever, and we are equally convinced that excluding the air from exposed surfaces in erysipelas is a proceeding based upon sound reasoning. I can only recall just at this time of writing one case in which the abdomen was reopened after a hysterectomy, but that case got well. I think the cautery plays an important *rôle* when the stump is to be dropped.

3. *Listerism.*—Only a day or two before receiving the letter from Dr. Bantock, I was honoured with a note from Dr. John Homans, of Boston, the main points of which, I suppose, by this time have found their way into the 'British Medical Journal.' This letter, together with some commentaries of my own, I have published in the 'Berlin. Klin. Wochenschrift.' This letter embraces all of his ovariotomies, with results, and expresses with succinctness his views about the 'spray.' Dr. Homans as an ovariotomist stands at the head of the list, or very near it, in the United States, and his statistics are the best of any operator there having an equally large number of cases. I have seen operations here by Schroeder, by Martin, by Gusserow, by Bergmann, and by Landau, and I have yet to see a single abdominal section *without* the spray. The apparatus plays away during the entire operation, and is only a very few feet removed from the patient's body. The operating room, especially at Dr. Martin's hospital, is surcharged with the vapour. The last two ovariotomies made by Dr. Goodell, of Philadelphia, which I remember, were both done under the spray. In a recent note from Dr. Marcy, of Boston, *full* Listerism is most strongly urged. With all of these operators the most complete antiseptic rules are enforced. At Martin's the room is filled with carbolic vapour, and the spray is kept constantly going. The hair is shaved from the pubes, and the vagina irrigated with bichloride solution. Then the abdomen is washed with brown soap and water, then with lemon juice, and then with bichloride solution. No one is allowed in the

room who is not absolutely aseptic, so far as it is possible to render himself so. All instruments, ligatures, needles, towels, sponges, &c., are kept in antiseptic (carbolised) fluid. All the water used is boiled. At Professor Schroeder's and at Professor Gusserow's the same strict details are carried out in all laparotomies. I can see no evidence that Listerism is on the wane, and unless the *world's* statistics could be properly arranged, individual figures of a necessarily restricted character can be of little importance. One man without the spray may have better results than another who uses it—because the former may be a more expert operator. I may say, however, that the amount of surgical gynæcology done with the spray (referring now more especially to abdominal sections) is far greater than that which is done without it, and the amount of general surgical gynæcology done under full antiseptic precautions is still far ahead of that which is done without it. The amount of such work done under these conditions in Berlin alone is simply *enormous*, and if general surgery be added to the list the figures would swell largely. Take, for instance, the figures from my list of operations of individual operators, and compare the numbers of those who use strict antisepsis with those who do not, and the preponderance is largely in favour of those using full Listerism. In the treatment of myofibromata of the uterus, individual results of those who use, and of those who do not use, the spray cannot be of much service, because the whole question may hinge upon the extra- and intra-peritoneal treatment of the stump, one man preferring one plan *with* Listerism, and the other using another way with the pedicle, *without* Listerism. When the opponents of full antisepsis urge the use of cleanliness *alone*, they must also include *ex necessitate rei* the exclusion of air from the wound. Now, why is this? Full cleanliness and fresh air go hand in hand, and if these views of a contagium vivum be without foundation, why exclude air from the united surfaces of the abdomen? It is not claimed that these low forms of life arise spontaneously, but that they are engendered by contact with the air, and in

certain pathological processes peculiarly adapted for their development. So far as the merits of the question go, it matters not whether the room be surcharged with the vapour or whether the spray is kept playing, the action of the antiseptic is practically the same. Speaking as one man, I should deem it a terrible loss to humanity if for any cause not founded upon absolute fact, this strict observance of antiseptic detail should be withdrawn from modern surgery. This impression has taken a firmer hold than ever before since my visit in Berlin. I hope at some remote day to have at command an elaborate table covering several *thousands* of cases done with and without Listerism. From the 3500 cases of all kinds the percentage is so far in favour of antisepsis.

Dr. BANTOCK regretted that the time of the meeting was exhausted. The three subjects introduced by Dr. Bigelow all afforded much matter for discussion. But he was especially anxious to say something on the question of 'Listerism.' He hoped he would have an early opportunity for this, as he was desirous of rebutting some misrepresentations under which he had laboured for some time.

The Society then adjourned.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, MAY 27th, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

Present: 41 Fellows, 9 visitors. The following gentlemen were elected Fellows of the Society:—Dr. Milne Murray, Dr. H. Sutherland, Dr. T. Wood Hill, Dr. E. W. Forster, Dr. R. R. W. Oram, Dr. W. T. Hudson, Dr. John Hackney, Dr. F. C. Batchelor, Dr. G. B. Fraser, Dr. W. J. Arnold, Dr. C. E. Steele, Dr. H. J. Stormont.

The following gentlemen were proposed for election:—Dr. D. A. D'Monte, Dr. Henry Blake, Dr. C. H. Joubert, Dr. Peter Giles, Dr. J. W. Byers, Dr. W. Whitla, Dr. W. J. Sinclair, Dr. W. Armstrong.

Mr. LAWSON TAIT showed ten cases of double pyosalpinx, in all of which the quantity of pus in the tubes had been small, the appendages very adherent, and the operation extremely difficult. All the patients had made easy, complete and rapid recoveries.

A Renal Calculus, removed from a young lady from South Africa, aged 24. Symptoms consisted of blood in the urine, and pain, both intensified by horse-back exercise, to which the patient was very much addicted. She made a very easy and rapid recovery.

The preparations of two cases of double pyosalpinx, together with abscess of the right ovary, in young women respectively 19 and 22 years of age. In both, the histories were almost identical, the mischief having been caused by gonorrhœal infection within a few days of marriage. In both the symptoms were extremely severe, the lives of both patients having been for months in jeopardy owing to the

recurrence of attacks of peritonitis. The gonorrhœa in both husbands was merely the heightening up of old gleet by the venereal excitement of marriage. The preparation from a case to all intents and purposes identical with the preceding two, save that there was no history of any infection, nor could any clue be given as to the origin of the disease, except that the patient began to menstruate within three days of marriage, and this probably was the source of the trouble. The disease in this case was diagnosed by Mr. John Clay, who was kind enough to place the patient in Mr. Tait's care. The operation was performed on May 26, and it was one of extreme difficulty, as the abscess burst, and very great care had to be taken in cleansing the peritoneum.

The preparations of two cases of extra-uterine pregnancy operated upon at the time of rupture, about the twelfth week, and similar in all respects to those of the series already published in the 'British Medical Journal,' with the exception of the last, which was operated upon on May 11, the pregnancy in this case occupying the part of the tube within the right cornu of the uterus, thereby forming an instance of the variety of tubal pregnancy known as the interstitial form. The symptoms were those of acute peritonitis, with intense pain arising apparently from a tumour which could be felt running from the right cornu of the uterus up towards the brim of the pelvis, shaped somewhat like a sausage. Its relations could be made out with great exactness, as the patient was a thin, small woman. It was supposed to be a sloughing myoma at the right cornu of the uterus, for no history could be obtained which in any way suggested tubal pregnancy. When the abdomen was opened a large quantity of bloody flocculent fluid escaped. The tumour was found attached as described, and was completely continuous with the body of the uterus. When handling it, in order to arrange for the treatment of the pedicle, it began to detach itself in the process of handling, and by a little gentle manipulation it easily separated, leaving a cavity shaped exactly like an egg-cup, and leading straight into the cavity of the uterus. Very

much to Mr. Tait's surprise, there was absolutely no hæmorrhage at all, so that after waiting about a quarter of an hour the whole thing was dropped back into the pelvis and the peritoneal cavity completely cleansed and closed. The patient has made a perfectly easy and rapid recovery. These two cases form the tenth and eleventh of this kind of cases on which Mr. Tait has operated, and all have made perfect recoveries except the first.

Dr. MORE MADDEN showed for Dr. Duke a speculum which obviated the objection common to most bivalve speculums of not affording sufficient room at the outlet for the use of the instruments on the os and cervix. The speculum has a spring, with the blades opening parallel, one of which can be made to divaricate so as to stretch the vaginal roof and open the os, if necessary. As the blades rotate, the instrument can be placed in any position in the vagina, either antero-posteriorly or laterally, a great advantage in operating on fistulæ or lesions of the vaginal wall, wherever situated. The instrument is made self-retaining by the divarication of the one blade, and thus leaves both hands of the operator free. Like every other bivalve, it is not suitable for all cases, but will be found a valuable one for use with multiparæ. One blade can be removed, and the other rotated and doubled back on itself, which makes the instrument convenient to carry.

Dr. BANTOCK exhibited specimens of uterine tumours, six being cases of supra-vaginal hysterectomy, and two removal by abdominal section and enucleation.

Taking them in order of date, they were as follows:—
1. A small tumour, about 2 lbs., removed by abdominal section and enucleation from a married woman aged 37, the mother of four children, the youngest three years old. First became aware of a tumour after her last confinement. For the last three months had suffered more or less pain, and for several weeks before admission to the hospital had been confined to bed. On admission the tumour was fixed, very tender to the touch, and had evidently been the seat of inflammatory action; the temperature ranged from 99° to 100·2°;

the tongue was red, tender, and fissured. It was impossible to make an accurate diagnosis. After about six weeks' rest and light diet, the patient improved considerably, and the temperature became normal. It was then determined to explore the case. This was done on Nov. 17. On opening the peritoneum adhesions were encountered between the parietes and omentum at the lower angle of the wound, between the tumour and the parietes and vesical pouch, between the tumour on the one hand and omentum and intestines on the other, and between the adjacent coils of intestines. The parietal and omental adhesions were separated, and several coils of intestine also; but it was found impossible to get down into Douglas's pouch. Although the tumour was now isolated in its superior portion, it was still impossible to say what its nature was, and as it was not deemed advisable to proceed further with the separation, on account of the serious bleeding, a medium-sized exploring needle was thrust into the tumour, and by aspiration 2 oz. of a thick puriform fluid drawn off. An incision was now made perpendicularly into the tumour, when the interior was found to present a very irregular surface, with innumerable hard spiculæ, which were subsequently ascertained to be calcareous. On examining the edge of the incision, an appearance of an envelope presented itself, and with some difficulty enucleation was effected. Then it was discovered the tumour was really a fibroid that had undergone degeneration. All bleeding points in the bed of the tumour were secured as far as possible by ligature and cautery; those in the intestines and separated surfaces were similarly treated, and the edges of the envelope were secured to the corresponding parietal edges in the lower part of the wound, while the upper part was closed in the usual way. The bed of the tumour was finally filled up with iodoform wool. The patient left the hospital in five weeks. The convalescence was most satisfactory; the temperature never rose beyond 100·2°, and was quite normal on the fourth day.

2. A multiple fibroid tumour, 2¼ lbs., from a married but

sterile woman, aged 36, and of rapid growth. The omentum was adherent in the region of the right tube, and had to be divided between two ligatures. Both Fallopian tubes were dropsical, and were aspirated, yielding three-quarters of a pint of thin, dirty-looking fluid. The uterus was removed at the level of the internal os, and the patient made a good recovery.

3. A tumour weighing 18 lbs., removed by supra-vaginal hysterectomy from a married woman about 40 years of age, who had had one child and two abortions. The tumour was discovered about nine years ago, after her second abortion. About a year afterwards she was in the Samaritan Hospital, under Mr. Spencer Wells, but, after examination under an anæsthetic, was sent home again. In the meantime, the tumour had grown very much, especially during the last few months; her general health had given way, so that she was on admission very thin, pale, and sickly-looking. During her stay in the hospital previous to operation she had a very serious hæmorrhage. The omentum (very œdematous) and mesentery were extensively connected with the upper and posterior aspects of the tumour, and after separation required many ligatures. Both Fallopian tubes and broad ligaments were very œdematous, and on the left side was a large hygroma, containing several ounces of bloody fluid. The uterus was removed at the level of the internal os, and the tubes and ovaries were included. The uterine cavity would easily hold my hand.

The patient died on the fourteenth day with failure of the kidneys. The case was a good illustration of the evils of delay, for had this patient been operated upon years before, the operation would have been an easy one, and at that time the general health would have been good and the kidneys sound.

4. A large submucous fibroid, weighing 11¼ lbs., from a married woman, aged 41, who had had one child and three abortions; very anæmic; menstruation lasting only four to five days, but excessive in quantity. In removing the tumour the broad ligaments were first secured by forceps, the peritoneum was divided all round the tumour, and reflected as low down as possible, and the *serre-nœud* was applied with

the transfixing pins, and the tumour cut away at the level of the internal os. The pedicle was exceedingly short, and the pins caused sloughing of integument on each side. The details of the case are too lengthy, and it must suffice to say that she left the hospital in two months quite well. Cystiform degeneration had begun.

5. This tumour, 5 lbs. in weight, made its appearance after the meno-pause in a married woman aged 51, the mother of four children, of whom the youngest was twenty-four years old. The broad ligaments were very short, and the same method of partial enucleation was practised as in the preceding case. The patient went home in about six weeks.

6. A submucous fibroid, weighing 9¼ lbs., obtained from a married woman aged 34. It was accompanied with menorrhagia, severe pain, and sickness, which, at each period, confined her to bed. In the course of the month, during which she lay in the hospital, for the purpose of observation, her circumference over the most prominent part of the tumour increased one inch. The operation was performed as in the two preceding cases, that is, by partial enucleation, so as to slacken the broad ligaments. The convalescence presented nothing remarkable, being throughout of the most favourable kind.

7. A single woman, a cook by occupation, and aged 37, furnished this tumour, which weighed only 3½ ounces. The pain had become so severe as to incapacitate her for her work. It was situated in the right cornu of the uterus, and was removed by abdominal section and enucleation. The uterine envelope was nearly a quarter of an inch thick on the peritoneal aspect. In consequence of the great thickness of the uterine tissues at the bottom of the bed of the tumour, and the great vascularity, I was afraid to trust ligatures, and I accordingly thrust a couple of pins through the base, and then applied the *serre-nœud*. On the third day there was oozing from the stump. The convalescence was otherwise uneventful.

8. The patient from whom this was taken was a governess, aged 25. Menstruation was only beginning to become slightly excessive, but the tumour was growing very rapidly,

and furnished the chief indication for operation. It consisted of a large cyst with very thick walls, and containing three pints of fluid. At the base the uterine wall was very much thickened on the right side. The right broad ligament was so strained, and the ovarian ligament so short, that this ovary had to be ligatured separately; the left was included in the loop of the *serre-nœud*, and the uterus was removed about the level of the internal os. The cavity was scarcely enlarged. Convalescence proceeding satisfactorily.

Dr. MANSELL-MOULLIN showed some diapers made by Hartmann. The diapers are composed of a sublimated gauze, containing a pad of the wood wool. There is ample absorptive power and complete antisepsis. Dr. Mansell-Moullin said they were light and comfortable to wear. When soiled they should be burned. The price was moderate.

Mr. LAWSON TAIT: As I moved the adjournment of this discussion for a special reason, I consider it my duty to open the adjourned debate. When I moved the adjournment of the discussion, I did so because I differed from the writer of the paper in almost every one of the opinions he had expressed. I did so when I heard the paper read, and I find that my view, or rather my opinion of the paper, has not been much modified by reading it. I differ almost entirely on every point in this paper, but I think it only fair to Dr. Madden to say, with regard to the paper, that it is an extremely fair statement of the case, as one could have received it until some three or four years ago, but from that time to now the conditions are very much altered, and we have been obliged, and are being obliged day by day, to alter our views very much. On the prime question which runs as a basis through the paper, we are altering our views almost daily. I venture to say on behalf of my friend Dr. Bantock, on behalf of my colleague Dr. Savage, possibly also Mr. Knowsley Thornton, and myself, that we are constantly finding reasons to believe that uterine myoma is by no means the harmless and non-fatal disease which Dr. Madden in his paper endeavours to make out.

Dr. Madden goes to the extent of saying that he believes that uterine myoma is a disease which has scarcely a mortality of 8 per cent. I know that in my own practice, because I have been able to watch the disease through a series of years, it is far more fatal than I could have thought. When you remember that we have no correct knowledge of the actual mortality of an ordinary disease, you will not be surprised when I say we do not know the actual mortality of myoma. I challenge anyone to put his finger upon any statistics which the world possesses which will show the real mortality of scarlet fever; and when you remember this, it is not surprising we do not know the real mortality of myoma. The fact is, there is myoma and myoma. The idea of the mortality which we had until the last five years was obtained from the records of post-mortems in cases where death occurred, not from myoma, but where myoma having been found to be present—a large number of bodies, chiefly of persons who died in real old age—the conclusion had been arrived at, which was absolutely unjustifiable, that myoma was a disease which, in a great number of cases, had no real significance, and which never terminated fatally. Cases which we are able to watch from one end to the other confirm us in the belief that uterine myoma is fatal in a much larger number of instances than is generally supposed. At the present time I can put my finger upon thirteen women who are dying of uterine myomata—thirteen women, more or less immediately under my care. These may be divided into two classes, one of which comprises ten cases. They have come chiefly to London, and chiefly to the practice of one specialist, who, seeing these patients three or four times a year, has been in the habit of saying, 'Come again in two or three months and see me,' and nothing has been done, and the tumours have grown steadily. The youngest is forty-three, and the oldest sixty. This list of cases explains to a very large extent the present high mortality of hysterectomy. I have regarded it as my duty never to refuse any patient the chance of relief by the removal of one of these tumours, so long as there

appeared the slightest prospect of success, and success has followed in apparently the most unfavourable circumstances.

The second class are those in which death occurs from hæmorrhage, and these are far more numerous than is generally imagined. Cases which have not refused to be operated on did not die, except in a few instances where we have had misfortune with the operation. There are two cases which I published four or five years ago, cases which were carefully watched month after month, year after year, and the results of which were so striking as to determine me absolutely, and to influence others very largely, in the course which we have followed in dealing with this particular class.

I must not go into the question of medical treatment, because it is very much like the chapter in the History of Ireland about snakes—there are no snakes in Ireland. The medical treatment of uterine myomata is a myth. Dr. Madden gives laudation to the treatment of tumours by hypodermic injection of ergotine, but we know perfectly well that as long as the case will submit to the risk, pain, and suppuration which follow hypodermic injection, the hæmorrhage is to some extent arrested, but the moment the treatment ceases the hæmorrhage comes back as violently as ever.

There are several passages in Dr. Madden's paper in which any such proposal is to be eliminated, because he tells us that he excludes a larger proportion as follows: 'In the first category should be placed all actively increasing fibromata not removable per vias naturales, and more especially those occurring in young patients in whom the prospect of reaching the period when any arrest of the tumour by the natural meno-pause might prove remote, and who, if they survive till then, are meanwhile necessarily condemned to lives of useless suffering.'

Now, it is with these cases that we have to do, because we have nothing to do with the cases of myoma which appear simply upon the post-mortem records. These are not the cases which come to the surgeon for treatment, whilst the suffering women do come.

Dr. Madden does me the honour to refer to me in this paper, and there is one sentence which seems to a considerable extent directed to myself:

'Hence I cannot but think that the enormous proportion of such cases met with in the practice of other surgeons must, in some degree at least, be the self-created result of the pre-conceived views of those who now find these operations so generally necessary.'

The opinion expressed in this sentence can only be based upon an ill-considered view of the relation of the medical profession to the public—an ill-considered view certainly of the relations between the surgeon and the public. I believe it to be true of myself, and of operating surgeons generally, that patients do not flock to their rooms in the first instance. We operative surgeons form a Court of Appeal. The patient comes to me, I know, and I believe it to be true about others, as a Court of second instance. I think there are very few on whom I have ever operated who have not come through the hospital or consultation with a private practitioner, but the 'self-created results of the pre-conceived views' are the result of three facts. My own opinion, the patient's suffering, and the consent of the practitioner under whose care she has been must be obtained before any operation is performed. Patients do not submit to operations, nor do we perform them, without due consideration and full discussion. We may, therefore, dismiss at once any criticism of this kind which has in the past been, or may in the future be, directed against this class of work.

We have to deal with suffering women, women whose lives we have to save from the growth of tumours and from the incident hæmorrhage, and we have to deal with them at their own request and with the consent of others, upon our own opinions and with the consent and judgment of those with whom we work.

A woman comes to me with certain symptoms. There may not be pain, in many instances there is no pain in question. It merely happens that a woman—more or less young—has a menstruation so severe that between the periods

it is impossible by any kind of care which she can be subjected to, any kind of rest, that she can make up the loss which she sustains during her menstruation. Patients do not come to me except in this condition, they do not come unless they have the need, and sometimes the condition in which they come to me is so ghastly that I am frightened even to suggest operation. I have a woman lying in the hospital now, of 52 years of age, who bled more than seventeen days out of twenty-eight, and her condition was that of profound anæmia. After fifty years of age it is generally supposed that the climacteric will arrive, but it very often does not. In this case it had been expected for two years, and hypodermic injections of ergot had been tried in vain, and a great variety of treatments had been adopted with no avail whatever. I have watched the case up to the age of fifty-seven without seeing the period arrive, and one of my colleagues has watched a case to sixty-one.

We have then this conclusion established by an abundance of evidence—that a woman with myoma in her uterus has the period of the meno-pause indefinitely arrested. Not long since my friend Dr. Priestley and I watched together a patient for years who had myoma bleeding abundantly. I urged that the operation should be performed, but it was decided that we will wait. We watched her until the present year, through ten long years of misery, she having a strong objection to the operation herself. She narrowly escaped death from hæmorrhage on several occasions. We know now that in these cases patients do not live under this hæmorrhage, and that the period is indefinitely postponed in a way which we did not know to be the case five years ago. But leaving aside for a moment the cases of myoma that come to us between the ages of forty-six and fifty, where we are all inclined to say let us wait and endeavour to arrest the hæmorrhage and wait for the period, we have still a large number of cases in which we have three proposals to submit to our patient, according to the condition in which we find her, and these three proposals are really the proper basis of discussion. We will take these proposals in order first.

Enucleation.—As I have said in this room before, and I will say it again, my experience of enucleation is so fatal—I do not know whether it is my fault or not, it may be my method of operation, it may be in neglect of Listerism—but my results are so fatal that I will have no more of it. I have had thirteen cases, and all have died but two! It really deserves, so far as I am concerned, the application of the word 'butchery;' and I do not think Dr. Madden's cases are really very far removed from the same definition. He has had two cases which very much resemble the cases of simple polypus, but in the description of his third case, we have this: 'In the separation of the tumour, which was as large as the fœtal head at the seventh month, the cervical tissue which had become disorganised by the pressure of the morbid growth and was, as usual in such cases, extremely soft and friable, was unavoidably lacerated. This rent extended downwards and backwards through the outstretched roof of the posterior vaginal *cul de sac*, and left a wide opening into the abdominal cavity,' &c. I have not read any further, but that patient recovered by the special interposition of Providence, and if there were one dozen cases performed, the mortality would be such as my own, and examples of that kind show us what to avoid, not what to follow, and therefore my view of enucleation, from my own personal practice, is completely established by Dr. Madden's cases, and I am sure that the majority of operators will agree with me.

We come, then, to the question of what Dr. Madden evidently regards, but with some inconsistency, as the more serious operation of the removal of the uterine appendages. There is a curious inconsistency in Dr. Madden's paper. He speaks of enucleation as quite a simple proceeding, and then, further on, speaks of it as never devoid of considerable danger. But I say that the removal of the uterine appendages in the earlier stages of the growth is always free from considerable danger. Supposing we get a patient somewhere between twenty-five and forty—and most of my patients are women between these ages—enucleation does not cure necessarily as other tumours grow. We have a large number of cases

under the age of forty, and I say that the moment uterine myoma is discovered in a patient under forty, her uterine appendages ought to be removed, and in this I am pleased to find that I have the support of Mr. Thornton. He has expressed that opinion before, and only last week he has expressed the same again—an opinion which my evergrowing experience shows me to be the best, and if carried out, the tumours will disappear as certainly as the patient recovers the operation.

Dr. Madden speaks seriously of the mortality attending this operation. He puts my own statistics against me, and he does so in a way not quite fair. The statistics show that out of ninety-nine cases there were seven deaths; but he does not do what he ought to have done, to have taken a sentence out of that paper, which shows that the great majority of these deaths were among my early cases. It is unreasonable to expect that my hands were as skilful in 1876, when I had done twenty cases, as now, when I have done 150. My mortality in removing the appendages for myoma in the early stage is, in my recent experience, absolutely *nil*. There is no mortality, or a mortality only so small as to be explained by the occurrence at times of unusual causes, such as tetanus. The deaths which I had in my earlier practice I do not have now, for I know how to prevent them. If a woman under forty has myoma, the removal of her appendages before she is profoundly anæmic will cure her, in ninety cases out of a hundred, and there is not one per cent. of risk in the operation.

The more we study this question the more I am certain we shall be convinced that there can be no doubt that it is the proper treatment for the early stages of these cases. For what are the arguments against it? The risk? That is *nil* or small as ever can be hoped for in my surgical operation. Sterility? The woman is sterile already, she will never bear any more children, and if she does become pregnant, she has before her the prospect of Porro's operation. The sterility therefore is an argument in favour of the operation. I think Dr. Madden will agree with the opinion which I have always held that the function of the surgeon is not so much to save death as to save suffering. I believe it to be a very

much higher function to relieve persons from disease than to save them from death; but to be able to cure them of a disease which has a heavy per centage of mortality, and to cure my patients to the extent of 90 per cent. with a mortality of one or two, I think is an extremely creditable proceeding.

I have no hesitation whatever in saying that I differ entirely from the view of the disease and its treatment which has been advanced in Dr. More Madden's paper.

The question of hysterectomy I think I had better leave to Dr. Bantock, as he has had far better results than anyone else save Dr. Keith. Dr. Madden quotes my own heavy mortality in this operation, but he ought in fairness to have quoted in full my sentiments in its condemnation and my expression of opinion that cases ought not to be allowed to go so far as to require it.

Dr. BANTOCK: As I had the honour of seconding the proposition, that the discussion should be adjourned to this meeting, I presume I shall be expected to follow Mr. Lawson Tait. And I would begin by saying that I entirely concur with the observations that have fallen from him. There can be very little doubt that the subject under discussion is one of the most important that can engage the attention of this Society. It is a subject that has been frequently discussed elsewhere, it has not escaped us during the short period of our existence, and, far from being exhausted, it is destined to furnish a theme for many years to come. Although it is now well nigh half a century since it may be said to have really made a start, the surgical treatment of fibroid tumours is still in its infancy. This arises as much from the protean and uncertain nature of the disease, as from the difficulties which beset the surgeon. For to determine when to operate is as difficult, and sometimes even more difficult, than to do the operation itself.

In the remarks I have to make it seems to me that it will be most convenient, for the purposes of criticism, to follow the order observed by the author, however erratic it may be.

The author enters on his subject with a statement of his pathology which is as peculiar as it is incorrect. For it is a

peculiar pathology which describes 'every growth of this kind as being primarily an interstitial myoma, which becomes more or less fibrous in structure by the development of its connective tissue,' and it is an incorrect pathology which describes these tumours as eventually 'becoming, by gradual increase in size, either subperitoneal or submucous.' Every fibroid tumour is not primarily interstitial. According to my observation, the site of origin determines the future character of the tumour, *i.e.* the class to which it belongs. I have seen them of all sizes, from that of a hemp-seed to that of a tumour many pounds in weight, as in this case. I have seen them in all sites and in all stages of growth, and the conclusion I have come to is that if a tumour begins as a true interstitial fibroid, it retains its envelope of uterine tissue to its largest growth. A subperitoneal or pediculated tumour begins as such and does not become less interstitial as it increases in size; and so with the submucous.

Ideas of treatment derived from such a pathology as this are certain to be as incorrect as the foundation on which they rest is unsound. And we cannot be surprised when the author says in his next sentence, 'Hence the operative treatment required in those cases in which any surgical interference is necessary should be mainly determined by the size and position of the neoplasm, rendering removal most feasible either per vaginam or by abdominal section,' nor that, in his opinion, the operation by the vagina 'is more generally possible, even in the case of interstitial fibroids, than is generally conceded.' There can be very little doubt that size and position combined have a very important bearing on the question of surgical treatment, but only conditionally. A small submucous fibroid will be best removed by the vagina, but when the tumour has already attained such a size as is illustrated in this drawing, or as in this tumour its removal would be impossible in any other way than by abdominal section. These tumours were both removed successfully by abdominal section. The difficulties are increased when the tumour is really interstitial. Such a one is illustrated by this small tumour which I hold in my hand, and which I

successfully removed by abdominal section and enucleation on the 29th of last month. In this case the tumour was situated in the right cornu of the uterus, and its envelope of uterine tissue was nearly a quarter of an inch thick on its peritoneal side, and was still thicker on the side next the uterine cavity. To have attempted to remove this by the vagina would have been an act of fool-hardiness, if not something worse. Therefore I am at a loss to understand the nature or extent of the author's experience, for it must have been of a very exceptional character to have led him to such a conclusion so diametrically opposed to my own. Nor do I know what he imagines to be generally conceded.

He goes on to say that, 'at the same time,' and while he confesses himself 'a believer in the advantages of hysterectomy and oöphorectomy by abdominal section for fibromata, otherwise beyond the reach of gynæcological assistance,' he is 'desirous to obtain some authoritative expression of opinion as to the limitations which should be imposed on these procedures.' 'For,' he adds, 'if the operative zeal now evinced in the performance of abdominal sections by some eminent surgeons be allowed to develop much further without protest, the legitimate employment of these procedures will be largely prejudiced by the inevitable reaction of opinion against such operations.' To whom does the author appeal for that authoritative opinion as to the limitations that are to be imposed on that operative zeal which he condemns? Does he appeal to those who know nothing of the operation, who have never done the operation, and probably have never seen it done? or does he appeal to the operators themselves? If to the former, then he ought to know that those are not the men to whom he can appeal for an authoritative opinion. If to the latter, then he ought to give them credit for the same conscientiousness that he assumes to himself.

He continues in these words: 'It seems to be entirely ignored by some of those who urge the early and general performance of abdominal operations for fibromata, that in the majority of cases these tumours may be as effectually dealt with by less hazardous procedures, and that in very

many instances they demand no operative interference whatever.' This sentence contains a mis-statement, a fallacy, and a well-known truth. For it is a mis-statement to say, even by implication, that there are any men who urge the general performance of abdominal operations for fibromata; it is a fallacy when he says it seems to be ignored, by the men of whom he speaks, that in the majority of cases these tumours may be as effectually dealt with by less hazardous procedures; for they not only ignore what the author asserts, but are well aware of the fact that they cannot be as effectually dealt with by less hazardous procedures; and it is a well-known truth when he asserts that in very many instances they demand no operative interference whatever.

When the author asserts that there can be no question 'as to the possibility of spontaneous cure by absorption,' he is on firm ground, though he is unable to adduce a single instance from his own practice, 'after a gynæcological experience of upwards of fifteen years.' But when he asserts the same as the result of medical treatment he will do well to tread lightly. Of the former I have seen but a single instance in a gynæcological experience of about twenty years. That case occurred in a woman aged 40, who at the end of her first pregnancy had a fibroid tumour as large as a small cocoanut, and which entirely disappeared within seven months by spontaneous cure. Of the latter I have never seen a single instance, nor even an approach to one. Nor can the author do more than allude to some cases 'elsewhere recorded' by himself, in which 'such tumours were thus notably reduced in size.' Unless he can produce more convincing evidence than that, he cannot be surprised if his views are very much called in question. Indeed, the author furnishes a contradiction of his views in the admission that 'the probability of such a termination in any individual instance is, however, too remote to have any material influence on the general prognosis and treatment of such cases.' Where then is the boasted efficacy of medical treatment?

Vulnerable as are his views when he deals with generalities, they are much more so when he descends to particulars.

Not content with a protest against the operative zeal of some eminent surgeons, he proceeds to make what amounts to a serious charge against the same men, and that too on the strength of his own limited experience. Mr. Lawson Tait has called attention to this matter, and I might be content with leaving it in his hands; but that there may be no doubt as to the similarity of our views perhaps you will allow me a few words. The author says: 'The cases of fibromata requiring either hysterectomy or oöphorectomy which have come under my own observation in the course of a gynæcological experience of upwards of fifteen years . . . have been, comparatively, few and far between. Hence I cannot but think that the enormous proportion of such cases met with in the practice of other surgeons must, in some degree at least, be the self-created result of the preconceived views of those who now find these operations so generally necessary.' I shall not attempt to characterise this statement, but I may be allowed to express the hope that the author will deem it incumbent on him either to explain it away or withdraw it. I would fain hope that it was written in haste to be repented of at leisure, and that he was not quite aware of the exact meaning of the words he had used. I do not believe that any man is influenced by the desire of being able to say that he has done so many operations of a particular kind. He may have the worthy and noble ambition of being able to say that he has done so many operations with so much success, so little mortality. But I hold every man free from that unworthy motive until he stands self-convicted. Of that unworthy motive Dr. Madden has no evidence whatever. For myself, I will say that I never approach even the contemplation of this operation of hysterectomy, which presents so many and such formidable difficulties, without the most anxious and serious consideration. When I look back on the cases I have done I am unable to reproach myself with having done a single case too soon, but on the contrary have to regret that I have not operated soon enough; and as it was in the early days of ovariotomy, when we were recommended by a distinguished authority not to operate until the patient

could no longer walk a mile, so has it been in the case of hysterectomy, the fatal verdict too often stands recorded 'too late.' Here, for instance, is a large tumour weighing 18 lbs. (No. 3 of the series) removed from a countrywoman of Dr. Madden's. This patient had been in the Samaritan eight or nine years ago, when the tumour could have been removed with the greatest facility. She was sent home, where she remained in more or less misery until at last it became necessary that something should be done. In the meantime her general health had broken down, and, amongst other things, her kidneys had become diseased. Though she made a good fight for life, living fourteen days, her kidneys at last gave way, and she died with complete suppression of urine. Here, again, is a very interesting case (No. 8 of the series) which I removed only this afternoon from a young lady aged 25. The tumour had grown very rapidly. It was one in which it was exceedingly difficult to determine what to do. Most men would have said 'leave it alone.' Fortunately I decided otherwise. The patient was a governess, to whom external appearances were of the greatest consequence. Taking this into consideration, and the fact that the tumour was growing rapidly, though there was no excessive hæmorrhage, I determined to operate. You see it was already cystic—containing three pints of fluid—and was just as dangerous as an ovarian tumour. I shall be very glad if Dr. Madden will inspect these tumours, for they will explain the principles which guide me in my practice.

Dr. Madden then goes on to contrast ovarian and uterine tumours, and while I agree with him in his description of the ovarian tumours as rapidly progressing as a rule to an ultimately fatal termination, I entirely disagree with him when he asserts of uterine fibromata that they 'never directly destroy life,' 'however much discomfort, suffering, hæmorrhagic discharge and impairment of health they may occasion.' Mr. Tait has already treated this part of the subject so fully that I need not add anything to what he has said.

In support of his views Dr. Madden approvingly quotes Dr. Keith, whose opinions always carry weight in proportion

to the very high estimation in which he is so deservedly held, and nowhere more so than in this Society. But there are two sides to the case, even as put by Dr. Keith. For if Keith admits that he has known most of his cases for years before operation, it is tantamount to saying that, had he operated on these cases years before, the operation would have been much less formidable, and the patients would have been spared years of suffering. But this is one of the difficulties we have to contend with, and it is only by extended experience that we can hope to arrive at a solution of the problem.

Just a word on the question of oöphorectomy which Mr. Lawson Tait has treated so fully, to note the peculiar way in which the author distributes his commendation. While I have the greatest respect for the name of Dr. Goodell, and while I regard him as one of the most eminent of American gynæcologists, I would not be misunderstood as disparaging his claims to distinction if I say that I was not heretofore aware that he had associated his name with this operation. Nor is the author much more happy in his selection of another whose name is associated with the proposition that hysterectomy should never be performed until oöphorectomy has been first tried and had failed—a proposition which I characterised at the time as both unscientific and unnatural, and of which its author has already seen the absurdity.

I fear I am trespassing too much on your patience, but I should like to say a few words on the subject of enucleation, which the author regards as 'a very simple matter.' That the removal of a small submucous fibroid, that can be readily extracted through the artificially dilated cervical canal, is not a dangerous though it may be a difficult operation, I quite agree with him. His first case confirms this view. But that it is a simple matter, either in its danger or difficulty, when we have to deal with a tumour several pounds in weight, I think the author is mistaken. In this I am supported by his second case, in which he only escaped disaster 'by the skin of his teeth.' I have done a considerable number of these cases, of which the largest weighed over 4 lbs., and I can assure Dr. Madden that not only were they difficult but they were ex-

ceedingly dangerous operations. Fortunately I have been more lucky than Mr. Lawson Tait, for all my patients have recovered. But I would not again undertake one of these cases of large tumour without a great deal more consideration than I have hitherto given them.

The author speaks approvingly of the operation of traction, or Emmet's operation. To commend this operation to our notice he quotes a case from his own practice, in which he neither succeeded in finishing the operation, nor in saving the life of his patient. Such a recommendation is not likely to meet with much acceptance.

Now, sir, I have finished my criticism. After the reading of the paper I stated that I was prepared to criticise it severely, but that I should hesitate to do so in the absence of the author. Now, in his presence, I have spoken freely, but I trust I have kept, as I have endeavoured to do, within the bounds of fair criticism. If I have said anything that may throw light on points that have hitherto been to him obscure I shall esteem it an honour. If, on the contrary, I have used any expressions which Dr. Madden may regard as too strong for the occasion, I would ask him to regard them as withdrawn. For myself, I consider he has done honour to our young Society by sending in his paper, and more especially in taking the trouble to come so far to take part in the discussion. If I have met his views with decided hostility, I can assure him that, personally, I am actuated by the kindliest feelings towards him.

Dr. MEADOWS: May I be allowed to interrupt? I know there are many Fellows of the Society who wish to speak on this subject. I think it would be a great pity that the debate should in any way be shortened. It is certainly one of the most important we could possibly have brought before us. It has never been so thoroughly thrashed out as it is likely to be here. I venture to suggest, therefore, that after the time of the usual ending of the meeting the subject should be adjourned until the second meeting in June.

Dr. MACAN (Dublin): I have nothing new to say on the

subject, not having read the paper. The paper under discussion to-night appears to go over the same ground as another paper which Dr. More Madden lately read in Dublin. The higher a tumour gets up in the vagina, and the larger it grows, the greater become the difficulties and dangers connected with the operation. I have spoken before on the question of enucleation, but I should like to draw attention to the method that has been developed by Herr Schroeder in Berlin, and which is also practised by Martin in the same city.

Dr. MORE MADDEN (Dublin): When I ventured to bring the subject of the treatment of uterine fibromata before this Society, my object was to endeavour to have the subject discussed, and though it has been now very fully discussed I trust it will be still further considered. I did not expect to have my opinions uncontroverted, and I certainly had no wish that if they were erroneous they should not be refuted. As to any warmth of expression used, I must say that I do not resent this in the slightest degree. In questions of this kind it is next to an impossibility to secure uniformity of opinion or practice, and therefore I would concede to others that same freedom of opinion that I claim for myself. We are here to discuss the great problem of how we are to deal with women suffering from one of the most serious of all uterine diseases. Within the last few years a new method of treatment has sprung up. For this method of treatment we are chiefly indebted to Mr. Lawson Tait, who introduced it in this country. It is a good many years ago since Mr. Lawson Tait brought forward the first myoma he thus removed by abdominal section. Since that time the operation has been growing in frequency, and many other operators have taken up similar views with a great deal of warmth and enthusiasm, which I fail to see has been justified by the results which have been achieved. In the statistics of Mr. Lawson Tait I find he lost 35·7 of the cases on which he operated. Now, I would say that if out of every 100 women suffering from uterine fibromata 35·7 must necessarily die from any operation, that method of treatment is not above criticism. We should not be led away by Mr. Lawson Tait's and Dr. Bantock's more recent greater

success. If the mortality were only one half of 35 per cent. I do not think we should be justified in exposing women to that risk for a disease which, however troublesome it may be, is, under ordinary circumstances, and as a general rule, not necessarily *per se* a fatal disease.

I recollect, when connected with the Rotunda Hospital under Dr. McClintock, a careful observer, who had seen a large number of uterine tumours, he told me that he had never seen a woman die from uterine fibroma. I myself never saw any woman die from it, and I doubt that anyone else has ever done so either. The trouble in cases of uterine fibromyomata arises from the hæmorrhage or from the pressure symptoms consequent on the neoplasm, and as a general rule these can to a great extent be controlled by measures less serious than hysterectomy. I have no doubt that cases occasionally occur in which either oöphorectomy or hysterectomy are indispensable, and I have had to deal with such cases myself. But I would repeat that they are the exceptions to a general rule. Hence, with regard to the mortality which admittedly follows abdominal section for the removal of uterine tumours—and Dr. Bantock and Mr. Lawson Tait admit that there is a large death-rate even in their hands—I do not think we are justified in exposing our patients to this if the mortality is greater than that of the disease; and therefore I think that the operation of enucleation, which is really a very simple operation, and which has been very successful in my own practice is preferable in suitable cases. At any rate I may in conclusion venture to say that however much I may differ from Dr. Bantock and Mr. Lawson Tait's practice with regard to the treatment of fibromyomata, no one can more warmly admire the operative skill and courage, or be more firmly convinced that they and every other member of this Society are equally striving, though by different means it may be, to achieve one grand object—that is the relief of human suffering and the advancement of the methods by which this can be obtained.

On the motion of Dr. BARNES, seconded by Dr. ROUTH, the discussion was then further adjourned till June 24.

ABSTRACT OF AN INTRODUCTORY ADDRESS

TO THE COURSE OF CLINICAL LECTURES DELIVERED AT THE HOSPITAL FOR WOMEN.

By PROTHEROE SMITH, M.D.

SENIOR PHYSICIAN TO THE HOSPITAL FOR WOMEN, LONDON; CONSULTING PHYSICIAN ACCOUCHEUR TO THE FARRINGDON GENERAL DISPENSARY AND LYING-IN CHARITY; VICE-PRESIDENT OF THE BRITISH GYNÆCOLOGICAL SOCIETY; CORRESPONDING FELLOW OF THE EDINBURGH OBSTETRICAL SOCIETY AND OF THE GYNÆCOLOGICAL SOCIETY OF BOSTON, U.S.; CORRESPONDING MEMBER OF THE IMPERIAL ACADEMY OF MEDICINE OF RIO DE JANEIRO; AND OF THE MEDICAL SOCIETY OF ST. PETERSBURG.

GENTLEMEN,—Forty-one years ago, before the establishment of the Hospital for Women, there existed no such public hospital in the world, and consequently the knowledge of uterine diseases was as faulty in diagnosis as in therapeutic methods of curing those peculiar maladies, for the more accurate study and treatment of which this hospital was then founded. These facts were proved by letters from Sir Charles Locock, Sir James Simpson, Drs. Rigby, Merriman, Conquest, Ashwell, Roots, Richard Bright, Hall Davis, Evory Kennedy, and several others, which were published in 1842. We therefore took the initiative in effecting a radical change in that department of medicine recently called gynæcology, not only by suggesting similar institutions in London and the provinces, and in various cities in Europe, America, and elsewhere, but by influencing the general Metropolitan Hospitals to devote wards for the study and treatment of diseases peculiar to women. Up to the present year the Hospital for Women alone has treated upwards of 90,000 cases, of which

7,177 were in-patients. Thus computing, in addition, all such cases in similar hospitals and wards, which have since been established throughout the civilised world, and regarding the improvement in diagnosis and treatment thus obtained, it is almost impossible either to overrate the great benefit to women, or adequately to estimate the advantages to the profession.

It is enough to know that many who have followed this speciality in practice have attained to great eminence, whilst very many lives have been thus saved which otherwise would inevitably have perished. From amongst a large number of letters I have received on this subject, I think you will be interested if I read you some extracts from a correspondent whose early and successful efforts, as a practical gynæcologist and as an accomplished operator and physician, give peculiar force to his remarks. Dr. Marion Sims, of New York, U.S., in July last, wrote to me thus:—

Limmer's Hotel, George Street, Hanover Square,
July 12th, 1883.

DEAR DR. PROTHEROE SMITH,—You were the first to establish a hospital specially for the treatment of Diseases of Women, and the hospital at Soho Square is the mother of the Samaritan, the Chelsea, the Birmingham, the Sheffield, the Liverpool, and others of the sort throughout the kingdom. You began the great work of your life in 1842. In 1845, not knowing of the existence of your hospital, I established one in Montgomery, Alabama, for Negro Women, and in this little hospital, of but twelve beds, after four years of incessant experiment, I worked out the problem of the curability of vesico-vaginal fistula, lacerated perinæum and congeneric affections. This could not have been done in any other way. In 1855 I established the Women's Hospital in New York, thinking at the time it was the first public hospital of the sort, and we so claimed it, till we found out that you antedated the Alabama Negro Hospital three years, and the New York Women's Hospital thirteen years. The honour then of being the first in this great work

belongs to you alone. The New York Women's Hospital is the progenitor of scores of similar hospitals all over our country, just as yours is here, and they are all doing wonders for suffering women. You do not claim too much in saying that these two hospitals, by their example and success, have been largely instrumental, directly and indirectly, in advancing gynæcological science in foreign lands, as well as in our respective countries. They proved that the diseases of women could be treated more successfully in special hospitals, in the hands of men who gave all their time to these affections, than in general hospitals, where the attention of surgeons was given to general surgery. Without a special hospital you and I could not have done the work we have done. Without a special hospital Sir Spencer Wells could never have accomplished the great work that makes his name immortal. Without it Simpson could not have made the discoveries and contributions which were so important in the foundation of gynæcology; nor could Thomas Keith have led us all in the marvellous success that places him foremost in the list of successful ovariotomists. Nor could Lawson Tait have done so much for abdominal surgery. Nor could Battey have inaugurated the great surgical revolution that hands his name down to posterity. Nor could Emmet have achieved his brilliant operation for lacerated cervix—an operation that must soon take the same rank here that it does in America. It is useless to give further illustrations of the advantages of special hospitals. They could be multiplied indefinitely.

But while we laud special hospitals, let us not forget to whom we owe the teachings that made them necessary. While you were first in hospital organisation, Henry Bennet was the first to demonstrate the importance of physical diagnosis and the success of local treatment. We owe everything to his indomitable energy and heroic perseverance. In his early days he endured persecution of the bitterest sort, but he triumphed at last and made the way easy for us to follow. I am glad to hear you are about to wipe out the debt and enlarge the hospital. I most heartily wish you every success,

and may you long live to witness the benefit daily conferred on our suffering sisters by the noble charity which owes its existence to your foresight, enterprise, and energy.

With kind regards, believe me, dear Dr. Protheroe Smith,

Yours most truly,

J. MARION SIMS.[1]

May it not with justice be said, as the old general hospitals have so signally failed to yield that practical knowledge to students generally which should fit them to exchange the lecture-room and 'walking the hospitals' for the onerous responsibility of practice, that the special hospitals should be called upon to take their part in the prescribed curriculum of education, and to supply that practical knowledge which students of their third year, with a view to succeed in practice, are so often obliged to seek for outside their schools of medicine?

I hope, however, this opposition to specialities in practice is at last yielding to the force of common sense, since the two last appointments to the Presidency of the Royal College of Surgeons have been held by specialists, viz.: by Sir Erasmus Wilson and Sir Spencer Wells. Still it is deplorable that so few of the medical men, annually qualified by law to practise, are taught to grapple with the numerous and serious maladies they will be called upon, by their female patients, to diagnose and treat. In this dilemma the Hospital for Women comes forward to throw open its extensive field of observation and clinical instruction to the medical profession. Not only will lectures be delivered here on special and general topics, but, by appointing clinical assistants and clerks, the work done in the wards and amongst the out-patients will supply a means, almost illimitable, for clinical instruction; and, to encourage such students in further efforts and industry, it has been proposed to offer annually, to the two best clinical assistants and clerks, a gold and a silver medal.

[1] I have thought it would be interesting to the profession, whilst mourning the recent loss of Dr. Marion Sims by sudden death, to publish here *in extenso* his letter, from which I read only extracts in my address.

Now, gentlemen, turning more particularly to the subject of our coming clinical instruction, I am desirous to say that whilst the female generative organs will form the staple whence we shall draw the matter to be treated of in our lectures, I am also anxious it should be clearly understood that we do not propose to regard them from an isolated point of view, but, looking to the body as a whole, we shall be able to show how all the various organs and their functions, which often yield important and distinctive features in uterine disorders, are related to and connected with the uterus and its appendages; and, on the other hand, how the latter act upon and influence the body generally and particularly, inducing various sympathetic affections, mental as well as physical.

Again, as regards the possession of a practical as well as correct anatomical knowledge of these parts, even when demonstrated and described by such an accomplished anatomist as our colleague Mr. Reeves, it would be insufficient to know them only as separate from their relation to other organs. Looking at the complex nature of the circulation and the disposition of the arteries of the pelvic viscera, the intricate distribution of their nerves (which you may profitably study in the beautiful and unique dissection by the late Dr. Snow Beck, which is preserved in our Museum), you will see that to endeavour to cure an uterine malady by local means only would be both empirical and irrational. Although we hope to bring before you many modern aids to treatment, both medical and surgical, yet, as the uterine organs are not exempt from such morbid influences and ailments as are common to every part of the body corporate, it should be clearly borne in mind that the knowledge, whether anatomical, physiological, pathological, or therapeutic, which, to the intelligent practitioner, suggests the fitting remedy for other parts of the body when diseased, is equally efficacious in the treatment of uterine ailments. We have, therefore, to press into our service helps, whether in the form of medicines, diet, nursing, and general hygiene, as well as the powerful aid of surgery.

Amongst the numerous operations which occur twice a

week in this theatre, you must have noticed, gentlemen, the frequency of ovariotomy. This is one of the modern means of combating a malady which formerly was almost invariably fatal. This operation already has saved thousands of lives, as it will probably save even more in the future. I operated on my first successful case in this hospital in 1843, without anæsthetics, which were then unknown, and the patient is still alive and in good health. It was not the custom in the early days of my practice to record so constantly in the medical journals, as is now done, the instances of one's success, and consequently my published cases bear no adequate relation to my operations. I must, however, confess that I have often regretted my inability, from want of time, to do more. I think it is highly commendable of Sir Spencer Wells, Dr. Keith, and other well-known authors, who have so ably recorded the result of their cases, and so have proved the truth of the above statement, showing approximately that, whereas ovarian disease formerly destroyed at least 90 per cent. of its victims, ovariotomy now saves life at the same ratio, although, within my recollection, time was when no one attempted, excepting by tapping, to meddle at all with ovarian disease. The great success attending this operation, however, has led to as great a change in medical opinion; and instead of the general apathy to everything gynæcological, this indifference has given place to the opposite extreme, and a zeal without discretion has, at times, produced the most disastrous results. Uterine examinations are too often suggested when no necessity calls for them; and to do something for an imaginary disease or displacement, hard metallic and other unyielding pessaries are employed, with the frequent use of lunar caustic for visionary ulcerations, which occasionally lead to inflammatory and other diseases. Again, some, for stenosis, split the cervix, whilst, on the other hand, Dr. Emmet and others adopt, with considerable success, the opposite plan of sewing it up, when a fissure occurs as the result of dystocia. Thus the knife has become more frequently of late the means employed, rather than such treatment as is suggested by right

diagnosis, implying a knowledge of general disease and of all the collateral influences arising from disorder of the respiratory, the circulating, and the nervous systems which tend so often to mask the real character of female complaints, and to produce hysterical affections, at times simulating organic maladies. Thus, to observe and obey God's laws, physical as well as moral, will often lead to a clearer view of the nature of diseases in women, and their remedies. Whilst fully admitting the claims of those who have lately advocated the use, in suitable cases, of modern abdominal surgery, yet, influenced by greater experience to follow in Nature's footsteps, and to treat the woman, as well as her disease, I hope we shall be guided to the adoption of further improvements, both in the medical and surgical treatment of these peculiar maladies, since gynæcology may be regarded as still in its infancy. And when the knife is considered to be imperative, I believe the *argumentum ad hominem* should finally decide its expediency, by the operator undertaking only such surgical measures as he would advise if the patient were his own wife or child.

It only remains to me, gentlemen, to bid you hearty welcome, and to declare that the clinical department of this hospital is now open to all who may desire to acquaint themselves with the speciality it is so well qualified to teach.

REVIEWS.

Spinal Deformity in relation to Obstetrics. By A. H. FREELAND BARBOUR, M.D. Being a Thesis for Graduation in Medicine at the University of Edinburgh, for which a Gold Medal was awarded in 1883.

THE subject of the thesis is divided into the three following parts:—(1) Changes in the form of the female pelvis caused by spinal deformity; (2) The displacements of the viscera in kyphosis; (3) The influence of these deformities on labour.

The work is based upon the careful examination of preparations in the obstetrical and anatomical museums of the Royal College of Surgeons of Edinburgh, and also of a cadaver of a kyphotic person who died immediately after childbirth.

Minute descriptions are given of seven kyphotic pelves, one skoliotic rachitic pelvis, and five kypho-skoliotic rachitic pelves. The summary of the peculiarities of the kyphotic pelvis based upon these preparations is given as follows:—

In the false pelvis the iliac crests are drawn out from before backwards; the arching of the crests is diminished, and their sigmoid curve lessened. The anterior superior spines are further apart than is natural. The true pelvis is funnel-shaped. Of the brim the conjugate is greatly increased, the transverse diminished relatively (to the conjugate), and sometimes absolutely. The promontory is higher (relative to the iliac crests), and displaced further back. The linea terminalis is less arched at the sides. In the cavity the conjugate is increased, but to a less extent than at the brim. The sacrum is narrowed transversely and elongated vertically; its vertical curvature is diminished

throughout; its transverse in the upper portion of the bone. At the outlet the conjugate is not usually altered. The transverse *may* be contracted, and even to an extreme degree, and the pubic arch is narrowed.

It is further stated that the most characteristic anatomical peculiarity of the kyphotic pelvis is an increase in the antero-posterior diameter of the brim—a condition which was found present in all the preparations examined. The contraction in the transverse diameter of the outlet, which is the feature of obstetric importance, is not so constant.

Six of the seven kyphotic pelves bore evidence in support of Breisky's statement, that the lower the region in which the disease is situated the more marked are the changes in the pelvis. One of the seven, that in which the angle was lowest, was an exception to this rule.

With regard to the etiology of the above changes, the author deduces from his researches that the explanation usually given is not quite correct. It has been stated that the sacrum has rotated round a transverse axis, so that the promontory has passed backwards while the coccygeal end has come forwards; that the innominate bones have rotated round an antero-posterior axis, so that the iliac crests have been thrown apart and the ischial tuberosities approximated. Breisky speaks of the backward rotation of the upper end of the sacrum as pressing the iliac crests apart. The author states that the preparations he refers to show that there is not, as a rule, a rotation of the sacrum round a transverse axis, and that the contraction at the outlet is not related to the elongation at the brim. He also complains that such a view leaves out of account the action of the muscles and the alterations in the axis of the brim necessary to the maintenance of the equilibrium. The author considers that the contraction of the outlet implies a rotation of the innominate bones, as shown in plate IX., where this exists so much that the brim is almost vertical.

We think that further study of this subject upon living specimens would greatly increase the value of these observa-

tions, and be more reliable from a practical point of view than the examination of skeletons alone. We believe that circumstances of movement and carriage make a considerable difference in different patients, and we have found that much less effort to balance the body has to be exerted when the diseased spine is sufficiently supported than without.

The curves of accommodation formed above, and especially the incurvation below the angle, may be greatly modified by fixation and carefully regulated support of the diseased spine, and thus alterations in the form of the pelvis would be materially modified, so that the *post-mortem* appearance of the angle of disease and the form of the pelvis would not always coincide.

With regard to the skoliotic and kypho-skoliotic series, as all the cases were those of rachitis, the question resolves itself into, 'How do these deformities modify the rickety type?'

The peculiarities of the kypho-skoliotic pelvis based upon the three preparations examined are as follows:—In the false pelvis the ilium on the side opposite the lumbar curve stands more vertical, and looks more inwards than the opposite one. The true pelvis is of the ordinary rachitic type, unless the kyphosis be low down, in which case it will be funnel-shaped. The brim is usually contracted in the sacro-cotyloid diameter of the same side as the lumbar curve, but sometimes in that of the opposite one.

In the cavity the unilateral contraction is less marked than in the typical rachitic pelvis.

The outlet is of the usual rachitic character, unless the kyphosis be low down, in which case it becomes relatively contracted. The ischial tuberosity of the side opposite to the lumbar curve is sometimes everted.

Part II. of this work consists of an elaborate description of the displacement of the viscera and the relation of the pelvic organs (*post partum*) in a case of kyphosis examined in frozen sections.

Part III. is a clinical study of these deformities with regard to obstetrics.

In respect to kyphosis, the most important part of the pelvis is the outlet, the transverse diameter of which is contracted, the peculiar form of the brim offering no obstruction to labour, thus differing materially from rickety cases where there is obstruction at the brim; but contraction of the outlet is not always present in the kyphotic pelvis. If the disease has developed before the tenth or twelfth year, the effects on the pelvis, says Chantreuil, will be serious. That is, we would add, if the kyphosis is severe and not high up in the dorsal or in the cervical region.

In labour the shortening of the abdominal cavity causes the uterus to incline forwards. The author also remarks upon the position of the child's head, and refers to Champneys's paper in the Transactions of the Obstetrical Society, 1883, in which a table of thirty-two cases is given. As regards operative interference, we have to consider the alternatives of forceps, embryulcia, Cæsarian section, or Porro's operation. In skoliosis and kypho-skoliosis the curvature may produce obliquity of the uterus, and thus interfere with its action.

In severe degrees of skoliosis the head will be arrested at the brim as in the simple rickety pelvis, and the kyphotic characters may cause delay at the outlet. As to operative interference, the use of forceps may be indicated, although the scientific treatment is, as a rule, turning; but turning will be more difficult than in a simple rickety pelvis, on account of the unilateral contraction which will give less room for the hand. In bringing down the head, this will pass more easily with the occiput to the roomy side of the pelvis.

An appendix upon the examination of another frozen cadaver gives some interesting information. The whole work forms a handsome folio volume, and is illustrated by thirty-eight well-executed lithographic plates. It is a valuable contribution to the literature of the subject, and we hope the author will pursue his studies further in this direction, especially as regards the observation of cases in the living subject.

E. NOBLE SMITH.

Handbook of Midwifery for Midwives. From the Official Handbook of Midwifery for Prussian Midwives. By J. E. BURTON, M.R.C.S., L.R.C.P. Second Edition, pp. 308. (London: J. and A. Churchill. 1884.)

THIS is a handy little book with very much in it, as there are scarcely any illustrations. The matter is thoroughly sound and very practical; the directions and explanations are so clear, and written in such simple language, that any midwife ought easily to understand them. This handbook need not be beneath the notice of the medical student when first commencing to attend labours; he will find it useful not merely as a book of reference, but it is worth his while to read it through. Its contents are systematically arranged, and there is a carefully prepared index. That a second edition has been called for is sufficient proof that it is appreciated.

HEYWOOD SMITH.

Clinical and Pathological Observations on Tumours of the Ovary, Fallopian Tube, and Broad Ligament. By ALBAN H. G. DORAN, F.R.C.S. Pp. 189. (London: Smith, Elder, & Co. 1884.)

THIS treatise is founded upon nearly 700 cases observed by the author at the Samaritan Hospital during the past seven years. He discusses many important pathological and clinical questions which have thus far not met with that amount of attention their importance demands.

The author believes that the common multilocular cyst of the ovary has its origin in Graafian follicles that have undergone partial involution without ever having developed into corpora lutea. These cysts rapidly involve the entire parenchyma of the ovary, growing away from the uterine appendages, and seldom involving the broad ligament; they contain glairy fluid, and sometimes adenomatous growths spring from their inner walls. Ovarian cysts containing papillomatous growths spring from the hilum of the ovary, originating in

relics of the Wolffian body; they do not rapidly involve the parenchyma, but tend to invade the layers of the broad ligament. Cysts arising from the vertical tubes of the parovarium, which is also a Wolffian relic, are also papillomatous.

What is generally described as a parovarian cyst certainly may, and does as a rule, arise, according to Mr. Doran, from the broad ligament itself quite independently of the parovarium, though he has traced a cyst of this kind to the terminal dilatation of the horizontal or efferent tube of the parovarium, which is generally pediculated, but sometimes sessile. A very frequent origin of the 'parovarian' tumour is the small thin-walled cyst, often developed between the layers of the broad ligament close to the ovarian fimbria of the Fallopian tube. The author has seen the entire parovarium lying intact upon a so-called 'parovarian' cyst. The hydatid of Morgagni, hanging from the fimbriæ of the tube, never develops into a cyst of any magnitude. The chapters devoted to the origin of ovarian, parovarian, and broad ligament cysts are abundantly illustrated.

Mr. Doran corroborates His' theory concerning the true position of the Fallopian tube, which accounts for its singular form when obstructed and dilated, and for the occasional position of an extra-uterine fœtus to the outer aspect, and sometimes almost inferior to the ovary in undoubted cases of tubal pregnancy. Out of nearly 700 abdominal sections, where the author was present or examined the structures removed, only one proved to be a true tumour of the tube.

The author gives statistics of thirty-one cases of dermoid cyst of the ovary, being the total number observed in the series of abdominal sections upon which the work is based, with the addition of an incomplete operation where a cyst of this kind had burst into the bladder. The youngest case of dermoid cyst was fourteen years old, and reference is made to a successful operation in Germany on an infant aged one year and eight months. In three of the cases the patient was over fifty years of age, the eldest being sixty-three; in this instance both ovaries were converted into dermoid cysts and

were successfully removed. The author also enters into the subject of sarcomatous growths occasionally associated with dermoid cysts.

The chapter on morbid conditions of the kidney associated with ovarian tumours shows the importance of resorting to early operation, as pressure upon the ureters at the brim of the pelvis is a frequent cause of diffuse interstitial nephritis, which the author regards as the chief cause of death in fatal cases of ovariotomy.

The work is one which will advance considerably our knowledge of all that pertains to ovarian tumours. It reflects great credit upon the author, and is a very praiseworthy effort to utilise for the benefit of the profession the vast field of study he has cultivated so diligently.

ARTHUR W. EDIS, M.D.

A Practical Treatise on the Diseases of Women. By JOHN THORBURN, M.D., F.R.C.P., Professor of Obstetric Medicine, the Owens College and Victoria University, Manchester; Obstetric Physician to the Manchester Royal Infirmary, &c. &c., pp. 575, and over 200 illustrations. (London: Charles Griffin & Co., 1885.)

THIS work, inscribed to his colleagues and to students past and present of the Owens College School of Medicine, the author states in his preface has been written with a very definite purpose.

'It is intended to afford the general practitioner of medicine, or the advanced student, a view of the present state of gynæcological knowledge and practice.

'Avoiding all personal "hobbies," and, as far as possible, all controversial matters, and using such judicially selective skill as I could, without dogmatism, bring to bear upon the discussion of each topic, I have endeavoured to go over the whole ground in such a manner as should be most practically useful in those emergencies which are daily occurring to every general practitioner.'

Coming from the pen of such an experienced teacher and conscientious worker as Professor Thorburn, it may well be imagined that a work of this kind would be full of sound and practical teaching, and a closer acquaintance very soon shows that this expectation is most fully realised.

After a preliminary chapter on the methods and means commonly employed in diagnosis, including a description of manual examination and the use of specula, sounds, and tents, the author commences with the diseases of the external genital organs. Subsequently he describes diseases of the vagina, uterus, ovaries, Fallopian tubes, and pelvic disorders, concluding with some chapters on dyspareunia, vaginismus, and sterility, affections of the female bladder and rectum, and the symptoms and signs of pregnancy from the point of view of diagnosis and differentiation.

That the opinion of the author on all points will meet with acceptation is probably saying too much. Turning to the subject of laceration of the cervix uteri, it is difficult to agree entirely with the cheerful view he takes that under the influence of hot-water vaginal injections such lacerations may often spontaneously heal if discovered within three or four weeks after confinement.

'If recognised at the time of delivery, the use of copious, tepid, antiseptic injections should be made from the beginning, and, indeed, for other reasons, this is advisable in all cases of delivery. In every case it would be well if a careful vaginal examination were made within three, or at most four, weeks after confinement. If this were universally done, many other conditions requiring early management would be discovered in time, and certainly this condition of laceration of the cervix would not give the trouble in after life which it undoubtedly often does. It can by that time be diagnosed with certainty by the finger, and its extent can then be ascertained by the duck-bill speculum. The hot-water treatment now comes into play.' Even at a much later period in his opinion repair of a lacerated cervix may be effected with-

out operative interference under proper management, and especially if strong caustics be avoided.

Some very practical and sensible rules are then laid down as to when operation is called for and when not. He would limit the operation to those cases in which, 1st, the torn surfaces are covered with thick granulations which have resisted simple treatment, and where evidently nothing but the curette or powerful escharotics will avail; 2nd, the lacerations and their consequent results have produced considerable ectropion of the cervical canal; 3rd, neuralgia or nervous phenomena of severe character can be traced, by exclusion, to nothing else than uterine origin, and to the possible involvement of uterine nerves in the cicatricial tissue of the cervix.

The chapter devoted to the subject of fibromyomata or fibroid tumours and their treatment is of great interest. The author is well acquainted with all the most recent views on the subject.

Referring to oöphorectomy as a means of bringing about the meno-pause and so arresting the troubles arising from a fibroid growth, he says (p. 273):—

'1. That with antiseptic precautions, in their truest sense, and with a fair experience of abdominal surgery in the operator, the operation is often by no means a very serious or difficult one. The removal of ovaries known to be the seat of chronic inflammation, and with chronic inflammatory surroundings and adhesions, is a totally different matter. Occasionally, however, when the operation is undertaken on account of fibroid tumours, very great and almost insuperable difficulties arise in finding or removing the ovaries and tubes.

'2. That in a very large proportion of cases, though not in all, the expected result as to the fibroid follows. I cannot more exactly estimate the proportion of successes.

'3. That the gravity of the operation is much less than that of enucleation and evulsion, or of removal of the uterus, or of a subserous fibroid, unless it is one with an exceedingly small pedicle.

'For these reasons I would advise that, in the case of a fibroid accompanied by very exhausting hæmorrhages, and when these had failed to yield to careful treatment as above described, and when the natural meno-pause is not presumably near at hand, recourse should be had to this operation.'

The work thoughout well maintains the author's promise. It is thoroughly up to date. It is written in a most pleasant and agreeable style, a quality that cannot be estimated too highly. The illustrations are well selected. It is certain to prove a most valuable assistance to those for whom it is intended.

J. MANSELL-MOULLIN, M.D.

SUMMARY OF GYNÆCOLOGY, INCLUDING OBSTETRICS.

OBSTETRICAL SOCIETY OF LONDON.

WEDNESDAY, APRIL 1st, 1885.

DR. JOHN WILLIAMS read a paper on 'The Circulation in the Uterus, with some of its Anatomical and Pathological Bearings.' After briefly sketching the course of the ovarian and uterine arteries as they approached the uterus, he remarked that all the primary branches entered the uterus on the side. They then ran a somewhat superficial course in a distinct layer of connective tissue. The muscular stratum between this layer and the peritoneum was thin, while that between it and the canal formed the greater part of the thickness of the uterine wall. The branches ran towards the mucous surface in a direction perpendicular to that surface, anastomosing freely, and ending beneath the mucous surface in capillary loops. The veins in the organ were arranged in a similar manner. The return of blood was said to be effected principally through the ovarian veins; but both these veins could be tied without appearing to materially affect the return of blood; indeed the whole pelvic venous system could be injected through any one of its larger trunks. The following conclusions were drawn: 1. The layer of connective tissue in which the arterial circles ran, and in which the venous plexus lay, was the submucous tissue of the uterus. 2. The whole thickness of the wall between this layer of connective tissue and the uterine cavity was the mucous membrane of the uterus; and the thin layer of tissue shed at the menstrual

period and reproduced (the menstrual decidua) was only a very small portion of the uterine mucous membrane. 3. The vascular arrangements were such that the circulation in the uterus could hardly be disturbed by mechanical causes. The entrance and exit took place at numerous points at the sides of the uterus, and in the uterus the direction of the current was transverse to its length and perpendicular to its surfaces; so that a ligature might be placed around the uterus at any point without affecting the circulation above and below. The only ligature which could materially interfere with the flow of blood into or out of the uterus was one surrounding each broad ligament, including their upper borders, together with a portion of the uterus. Conditions like these were found when the uterus formed a hernia in the inguinal canal, or in Douglas' pouch, in the condition usually spoken of as retroflection or retroversion. Both conditions were those of true hernia, and the symptoms were largely due to constriction at the neck of the sac, formed (in posterior hernia) by the sacro-uterine ligaments. In procidentia, again, stretching of the vessels might produce considerable narrowing of their calibre. These two conditions—hernia of the uterus and great procidentia—appeared to be the only displacements of the uterus which could give rise to congestion of that organ.

Case of Absence of the Uterus and Occlusion of the Vagina.—Dr. Bousquet (Marseilles) described this case. The patient, aged 20, had never menstruated, but had suffered from hæmorrhages at the usual periods, sometimes from the rectum, sometimes from the gums, lasting four or five days. When seen, the hæmorrhage had lasted two days; the gums were swollen, painful, and bled on touch. Combined examination discovered no uterus. The author then cited a very similar case of Dr. John Clarke's in St. George's Hospital, followed by necropsy, in which ecchymoses were found in the skin, pleuræ, and pericardium, together with old endocarditis. The author regarded these cases as proof that the ovarian nixus was sufficient to cause vicarious menstruation when the natural channel was absent.—Dr. John Williams did not think

either of the cases were examples of vicarious menstruation, but of purpura in women without uteri.—Dr. Routh expressed a similar opinion.

J. MANSELL-MOULLIN, M.D.

OBSTETRICAL SOCIETY OF EDINBURGH.

WEDNESDAY, FEBRUARY 11th, 1885.

Dr. Skene Keith showed a lobulated fibroid removed from a patient some time since. The bulk of the tumour had been a source of inconvenience. The patient is now quite well and fit for work.

Dr. Peter Young read a paper on 'A Case of Pulmonary Thrombosis in a Puerpera.'

Dr. Angus Macdonald read a paper on 'Pregnancy in the Left Horn of a Bicornuus Uterus, successfully removed by Laparotomy.' Specimen exhibited.

Mrs. B., *æt.* 23, was admitted January 8, 1885, complaining of an abdominal tumour; general health previously good. She had been married four years, and has one living child, which was born on March 9, 1882. Menstruation occurred for the first time after the child's birth in the end of February, 1883. After this she did not menstruate again, but considered herself pregnant, and felt life first in June. On January 1, 1884, she had very severe pains, lasting with scarcely any intermission for three days. On the third day a red discharge appeared in lumps; one lump was bigger than the rest, and was pronounced by the doctor in attendance to be a bit of a 'conception.' The discharge stopped on the following day, and the pains gradually left her. She remained in bed for three weeks at this time, and then resumed her ordinary duties. Menstruation reappeared in March 1884, and has been regular since. A bad-smelling yellow discharge was noticed on one or two occasions.

On examination the sound entered a cervix of the usual firm, non-pregnant character, to the distance of a little over 2½ inches, and a hard tumour, movable, smooth, and

continuous with the cervix, without any bruit, occupied the abdomen.

From the physical examination and the history of the case, which previous to the operation had been but very imperfectly obtained, Dr. Macdonald, considering he had to deal with a rapidly-growing fibroid tumour in a young woman, decided to remove the growth.

The operation was performed on January 26, 1885. On proceeding to remove the tumour its true nature became apparent.

The patient's recovery was uninterrupted.

Dr. Macdonald considers this case may afford an explanation of 'missed labour.' In a number of these unicornual pregnancies the horn no doubt ruptures early; but if the bifurcation divides the uterus nearly equally pregnancy may advance to full term.

If, then, there is either an absence of tubular communication between the one horn and the common cervix, or if that connection, though present, is radically narrowed and incapable of dilatation by the uterine contractions, labour becomes impossible; no progress whatever is made under the influence of the pains. The fibres have no opportunity to recover force when out of tension, as happens in ordinary labour cases, when the cervix opens up under the influence of the pains, and consequently the uterus rapidly gives up work by exhausting its contractility.

J. MANSELL-MOULLIN, M.D.

ACADEMY OF MEDICINE IN IRELAND: OBSTETRICAL SECTION.

FRIDAY, MARCH 10th, 1885.

Menstrual Decidua.—Dr. F. W. Kidd exhibited a very complete decidual cast of the uterus, obtained from a patient whose history did not point to pregnancy as a cause. The size of the cast was scarcely greater than that of a non-gravid uterus, and he was inclined to regard it as an unusually perfect

menstrual decidua which had been expelled entire.—Some discussion ensued as to the exact nature of the specimen, which, with the consent of Dr. Kidd, it was finally determined to refer to the Committee of Reference for examination.

Demonstration Speculum.—Dr. Neville, Sectional Secretary, exhibited for Dr. H. Macnaughton Jones a new speculum, designed to show the cervix to a number of students in a class at the same time. The image of the cervix was thrown upon a good-sized mirror, so jointed on the speculum (a metallic Fergusson's) that it could be moved freely about in any direction.—Dr. Macan and Dr. Dill both expressed their conviction that the instrument would achieve its objects and prove very useful for teaching purposes.

Artificial Vesico-Vaginal Fistula for the Cure of Chronic Cystitis.—In the discussion that followed the reading of this paper by Dr. Macan, Dr. Atthill considered many cases of chronic cystitis amongst the most intractable of diseases when treated by ordinary methods. He had frequently recommended the making of an artificial fistula in such cases, and looked upon this measure as the only one likely to end in cure when the cystitis had lasted for some time. His great difficulty was in persuading patients to undergo such an operation.—Dr. Doyle believed that the credit of originating this plan of treatment was due to Sir H. Thompson.—Dr. Neville said that, so far as he knew, the operation under discussion was first advocated and performed by Emmet, of New York. The operation was designed to give rest to an inflamed part, and was a practical application of the principles well enunciated by the late Mr. Hilton in his work on 'Rest and Pain.'—Dr. Foy was under the impression that the operation had been done earlier than by Emmet or Sir H. Thompson.

Some Points in the Diagnosis of Pelvic Hæmatocele.—Dr. Neville read this paper for Dr. W. J. Smyly. The discussion was postponed until the next meeting of the Section.—J. MANSELL-MOULLIN, M.D.

Trachelorrhaphy.—Dr. Vulliet, of Geneva (in the 'Archives de Tocologie'), reports twelve cases of operation for laceration

of the cervix. He has performed trachelorrhaphy for the last two years, and in his experience believes it to be the simplest, surest, and most inoffensive method of curing a category of disorders which date from a parturition where the cervix has been lacerated. If the patient be courageous, and the uterus can be drawn down readily to the vulva, he does not produce anæsthesia, the operation not being very painful. He prefers the dorsal position, and brings down the cervix as near to the vulval orifice as possible by means of volsella applied to each lip. He lays great stress upon the importance of vivifying thoroughly the surface, excising carefully the whole of the cicatricial tissue, either with the bistoury or scissors as found convenient. Only one of his cases was kept in bed for a fortnight, the others were allowed to get up before the fourth day.—ARTHUR W. EDIS, M.D.

Permanganate of Potash in Amenorrhœa.—Dr. Deas, in the 'British Medical Journal,' April 18, 1885, states that he thinks permanganate of potash as an emmenagogue has not been followed up so much as it deserves. He has employed it chiefly in obstinate cases of amenorrhœa associated with mental derangement, either as the cause of the latter or as a coexisting condition, both depending on a common cause, such as sudden shock, fright, &c. The first case in which he tried the permanganate was that of a young woman, who had broken down in health from the effects of prolonged nursing of a sick relative, and the anxiety connected therewith. The catamenia were suppressed, and the patient fell into a state of general bad health. After a time, mental symptoms supervened of the nature of melancholia with stupor. When, after some months, she came under his care, the catamenia had been suppressed for about a year, and the general health was much below par, with constipation, anæmia, and general want of tone; the mental symptoms being obstinate taciturnity (never speaking a word), volitional power almost entirely in abeyance, and a tendency to the cataleptic condition.

Various remedies had already been tried for the amenorrhœa. She was treated on general principles for two or three

months, with no change beyond some little improvement in her general health. Permanganate of potash was then prescribed in pills of one grain, one three times a day, and increased after a time to two grains three times a day. After taking them for about two months, the catamenia appeared, and almost simultaneously a rapid improvement set in in her mental condition and general health. She was watched carefully at the next period; the pills were renewed for a week before, and hot hip-baths administered. The catamenia appeared, and from that time the patient made a rapid and uninterrupted recovery. Dr. Deas has employed the permanganate with equal success in other cases. He concludes:—1. Permanganate of potash is a useful and safe emmenagogue, and free from the disadvantages which attend some other remedies of this class. 2. Its use may be continued for months without any bad effects, and success need not be despaired of even after many months. 3. Even when it fails as an emmenagogue, it acts beneficially as a general and nervine tonic. There is no doubt that, in many cases of amenorrhœa, more particularly where the catamenia have been suppressed, as from chill, shock, or other cause, the permanganate is valuable. I have, however, preferred to give the drug in the form of tablets. I think them more certain in their action than the pills. The compressed tablets made by Burroughs, Wellcome, & Co. are convenient and keep well. After meals is the safest time to give the tablets, and half a tumblerful of water should be taken with each tablet. Although there are cases where the permanganate of potash is a most effective emmenagogue, it is by no means universal in its application. I have found the establishment of the menstrual function secured in several cases lately under my care by the administration of Fellows' hypophosphites. In badly nourished anæmic girls with small ill-developed uteri, the hypophosphites will be found to give better results than the permanganate of potash. Occasionally the alternate administration of the drugs is useful.—FANCOURT BARNES, M.D.

Laceration of the Cervix Uteri.—In the 'Medical Chronicle,' March and April, 1885, Dr. W. J. SINCLAIR, in discussing lacerations of the uterine cervix, founds his views on the results of twelve operations upon ten individuals. He believes that the profession in England has too much neglected an operation which he is convinced may sometimes confer benefit when no other treatment can be of permanent advantage.

In every case operated upon by him the laceration has been deep and distinct, and the patients have been great sufferers, many having been under constant treatment for years previously.

After giving a detailed account of his cases, the author remarks that his experience is too limited to justify a dogmatic method of dealing with the subject, either as to details of surgical procedure or as to the opinions of operators who count their cases by the hundred; still, the critical examination of a few typical cases that have been operated upon, and of many that have come under observation without being submitted to operation, can hardly fail to suggest some ideas worthy of consideration and development in the present equivocal position of the operation in this country.

He draws the following conclusions:—

The preparatory treatment recommended by Emmet is quite unnecessary. If the cervical catarrh with erosion, and all the complications, were originally produced and are perpetuated by the cervical laceration, then it seems irrational to spend weeks and even months in trying to cure the catarrh, as a mere preliminary step, and that by proceedings almost as severe as the operation itself. His most recent cases have had no preparation except a few days' rest in bed to relieve the uterine congestion, and the daily use of the syringe with warm water on account of the discharge; and the results have been all that could be desired. Chloroform may be dispensed with. This makes the operation much less formidable, both for surgeon and patient. He considers it advisable to give a hypodermic injection of morphia half an hour

previous to the operation to relieve the pain caused by the introduction of the sutures.

In cases complicated with retroflexion and hypertrophy the results are less satisfactory. In such cases the operation should be regarded as only an essential step towards the cure of the ailment.

The symptoms associated with laceration depend almost entirely upon the complications in more or less close causal relation with the laceration. The most common of these are subinvolution, 'erosion,' retroflexion, and parametritis. The last of these is apparently the most formidable, and its existence has been maintained to be a contra-indication to the operation. He considers the fear of re-establishing the inflammation to be perfectly groundless in cases in which the parametritis is really of traumatic origin, not specific, and the proceeding which restores the cervix cures the remaining cellulitis.

The process of cure is very gradual where any complication has been present, and the dissatisfaction which has often been expressed regarding the operation has probably been due to want of patience. Some time must necessarily elapse before the results are complete.

The author disagrees entirely with Emmet's statement that laceration of the cervix is often the starting-point of epithelioma. In the cases of uterine cancer which he has examined at a comparatively early period there has been no evidence of laceration. He believes the admitted difficulty of diagnosing extreme erosion from epithelioma in its early stages has given rise to this statement. The extreme form of erosion he has noticed more particularly in cases where the laceration-ectropium is complicated with flexion, and the body of the uterus flexed over the lip on which the erosion existed.

'The operation of trachelorrhaphy has been the object of a good deal of ridicule because of the practice, formerly very common, of incising the cervix in the course of treatment. The new procedure is said to be merely a reversal of the old

practice of gynæcologists, who feel that they must do something, if merely for the sake of appearances. One American surgeon who takes this line of argument (Dr. Clifton Wing, 'Boston Medical and Surgical Journal,' 1880), goes the length of telling how two specialists in one city, who took opposite views on the value of Emmet's operation, made work for each other, one of them stitching up the incisions which the other had made in course of his practice. The objection has a sort of superficial plausibility which has obtained for it currency and popularity—after the manner of all superficialities; yet the slightest critical examination is all that is required to expose its hollowness. The incision made in the posterior lip of the uterus in the process of treatment of dysmenorrhœa from anteflexion, for example, is comparatively a trifling affair; it does not cause ectropium, and, indeed, one of the chief objections to the proceeding is the difficulty in retaining any benefit derived from it because of the tendency of the wound to heal and leave no trace of its existence. To speak of the making of such a wound as the reverse process of trachelorrhaphy is simply ridiculous. It is a confusion of thought, treating a complex organ as a simple entity, and comparing things as different as if they lay at the opposite extremities of the body. It would just be as relevant and rational to sneer at the operation for restoring the perinæum, because some obstetricians have practised the making of lateral incisions during parturition—episiotomy—to prevent laceration in the median line. If there is any solid argument of general application to be urged against trachelorrhaphy, it would be as well if the opponents of the operation would produce it, and withdraw this specious makeshift which appeals only to ignorant prejudice.'

Trachelorrhaphy possesses a solid basis of merit, and can hardly fail, when it has received an impartial trial, to supersede some of our painful, tedious, and futile scarifications, cauterisations, and intra-uterine medications, and to be recognised as supplying in suitable cases a valuable addition to uterine therapeutics.

J. A. MANSELL-MOULLIN, M.B.

CLINICAL AND PATHOLOGICAL REPORTS.

Report of the British Lying-in Hospital for 1884, by Heywood Smith, M.D., and Fancourt Barnes, M.D., Physicians to the Hospital.

In the year 1884 there were 132 deliveries in the Hospital with two deaths, giving a mortality of 1·5 per cent. There were born 68 male children, or 51·5 per cent., and 64 female, or 48·4 per cent.

Of the mothers 34 were primiparæ, or 18·18 per cent., 98 were multiparæ, or 74·1 per cent.

Of the children three were stillborn, or 1·45 per cent. There was one case of craniotomy in a patient with a tryphotic pelvis; the mother recovered.

There was only one breech case, and no case of post-partum hæmorrhage, nor of turning. In one case Dr. Fancourt Barnes had to deliver the patient by Porro's operation, on account of a dermoid cyst blocking the pelvis. The patient died of septicæmia on the fifth day; the child, a male, survived. Of the two deaths of mothers mentioned above, this was one; the other death being from puerperal septicæmia with pneumonia in a primipare, æt. 19, 18 days after delivery. There were three deliveries by forceps; in one of these cases the patient, a multipara, was the subject of universal anasarca with albuminuria. The child, a stillborn male, and placenta were both dropsical. Notwithstanding the fact that delivery was prolonged and difficult, the mother recovered from the lying-in and her albuminuric condition without any rise of temperature.

Although the number of operative cases was below the average, there was a larger percentage than usual of difficult operations, three of the patients delivered by operation having been sent into the Hospital for operation after having been seen by medical practitioners outside the Hospital.

In one case labour was obstructed by a large fibrous tumour of the uterus which completely blocked the pelvis; this was pushed up by Dr. Heywood Smith, and labour was completed naturally.

The morbility in the Hospital was, as it has been since the

beginning of the year 1881, when the antiseptic system was introduced, extremely low. The number of patients who exhibited symptoms of pyrexia is as follows: Among the primiparæ 11 had a temperature of under 100° Fahr., or 8·3 per cent. Among the multiparæ 68, or 51·51 per cent. Five primiparæ had a temperature of over 100° Fahr., but not over 101° Fahr., or 3·78 per cent., and eight multiparæ, or 6·06 per cent., showed similar conditions. In 40 cases, or 30·3 per cent., the temperature rose above 101° Fahr.

The above figures show that it is quite possible to deliver women safely and free from the risks of puerperal fever in a lying-in hospital. They are, indeed, most reassuring; especially as they are but a repetition of similar good results during the last three years at the British Lying-in Hospital. During these years the Hospital has been absolutely free from any epidemic of puerperal fever. The mortality during the first three years of the four was only ·5 per cent. In 1884 it is true that it rose to 1·5 per cent., but this rise was occasioned by a death after a Porro's operation.

CORRESPONDENCE.

To the Editor of the British Gynæcological Journal.

SIR,—Observing in the British Gynæcological Journal for April that Dr. Aveling's information as to the origin of Hospitals for Women is somewhat obscure, I shall thank you if, in your next issue, you will do me the favour to publish the inclosed introductory address which I hope may make it more clear; and I think the letter of the late Dr. Marion Sims, written just before his death, cannot fail to be acceptable to gynæcologists and to the profession generally.

Yours faithfully,

PROTHEROE SMITH.

42 Park Street, Grosvenor Square, W.
May 4th, 1885.

OÖPHORECTOMY *VERSUS* PUERPERAL MANIA.

To the Editor of the British Gynæcological Journal.

SIR,—Your brief note with this heading comes to me with a surprise for which I cannot find adequate expression. That Sir Spencer Wells should have so altered his opinions upon the propriety of removing normal ovaries, after having expressed himself so strongly adverse to such a proceeding on more than one occasion, certainly is strange, but it is no less gratifying.

In the large amount of work which I have undertaken concerning the removal of the uterine appendages I have carefully steered clear of that most difficult question of performing such operations for purely nervous symptoms, with the exception of six cases of epilepsy of which I have given full details. So far as I know no one has ventured any further on this doubtful ground.

The reason of this, so far as I am concerned, was that I found my work surrounded with difficulty on account of adverse and, in very many instances, most unfair criticism, in which Sir Spencer Wells has taken a considerable part. I therefore felt myself obliged

to keep free from the possibility of any trouble which might arise, and certainly would have arisen, upon such a point as this, though I have been all along persuaded that there are many cases of mental disorder in which the removal of the uterine appendages could be justified on medical as well as on moral grounds. Now that we have the senior gynæcologist of this country setting us the example we may with perfect freedom from any fear of misfortune discuss the subject, and probably we shall add another to the already numerous victories of our art. We may be at least certain that now there will be no fear of any further animadversions to the effect 'that abdominal surgery in its latest developments is open to the denunciation hurled against the earlier ovariotomists; and that, with more reason than in 1850, Lawrence's question must be repeated, whether such operations "can be encouraged and continued without danger to the character of the profession," and West's assertion that "a fundamental principle of medical morality is outraged" cannot now be satisfactorily refuted' (Spencer Wells, 'Medical Times and Gazette,' July 5, 1884).

I am, Sir, your obedient servant,

LAWSON TAIT.

7 The Crescent, Birmingham:
April 21, 1885.

OBITUARY.

WILLIAM JOHNSON SMITH, M.D.

It is with sincere regret that we record the death of one of our Foundation Fellows, Dr. William Johnson Smith, of Weymouth. From the commencement of his career he had identified himself with gynæcology. Dr. Smith was the third son of William Smith, of Smithborough and Orchard Vale, Ireland, by Elizabeth, sister of the late Sir Edward Johnson, K.C.G., J.P. Dorset, Lord of the Manor of Godmanstone, Dorset, and Smithborough, Ireland. He graduated at Edinburgh in 1842, and studied at Paris at the same time as Henry Bennet, Robert Barnes, and the late Dr. M'Clintock, of Dublin. He was extremely popular in Paris, and was made secretary of the Parisian Medical Society. Before this Society he read a memoir, stamped by the best qualities of originality and judgment, 'On the Posture of Woman in Labour.' It was much above the level of youthful essays. Settling in Weymouth he quickly made his mark.

In 1848 he determined to found a hospital for women. At that time it required no small courage to encounter the public and professional prejudices which such a scheme had to encounter. But Smith had all the qualities of a founder: earnest conviction, unselfish philanthropy, and a strong scientific instinct. His personal character disarmed hostility and attracted friends.

The story he tells of the foundation of the Weymouth Sanatorium is characteristic of the man and interesting. He issued an appeal, to which a lady responded by sending him 10*l.* 'Small beginnings,' he said, 'end in large results very often; and the receipt of this 10*l.* was in consequence of my having issued a pamphlet in which I gave my experience of two years in a small room which I rented for the purpose of giving advice to the poor. I remember it so well that the pamphlet had not been in the hands of the public more than six hours before I had this gift of 10*l.* But then came afterwards what perhaps you will say was an unpleasant circumstance. Before I had finished my breakfast I had a visit from my uncle, Sir Edward Johnson, who came with my pamphlet in his hand. He said to me, "William, what do you mean by this?

You are going to bring all the medical men in Weymouth upon your back. You will not be able to keep your position, and what is more, you will not get a penny towards this institution." "Oh, well," I said, laughingly, "I am very sorry you view matters in this light, but I will prove you are not entirely correct, inasmuch as I have already received 10*l.*" I then put my hand on his shoulder and said, "What will you give me?" He could not resist my appeal, and laughing, said, "This is more than I expected." I said to him, "I will not allow you to fix what you will give me. I only ask for the same amount as this good lady has given;" and from this origin this institution began.'

Nearly forty years have elapsed since this, and Dr. Smith has seen the complete success of his enterprise. The institution flourishes in a freehold, and with an endowment of 7,000*l.* Financial prosperity has been enhanced by moral success. Dr. Smith's name will always be honourably associated with those who initiated the movement for the emancipation of gynæcology from the obloquy and disabilities by which this department of medical science had been oppressed. He cordially hailed the foundation of the British Gynæcological Society, which is the real charter of the freedom of gynæcology.

How completely Johnson Smith triumphed over all obstacles, how thoroughly he won the hearts as well as the esteem of all who came in contact with him, is proved by the public and private honours that graced his funeral. His death is mourned as a public loss. All ranks, all professions, all classes of his fellow-townsmen and of the county of Dorset joined in the last tribute of respect. Not the least gratifying testimony to his worth was that tendered by his professional brethren. How it would have delighted the heart of his uncle, Sir Edward Johnson, could he have witnessed this, the dearest recognition of his worth, the happy falsification of his early fear!

Dr. Smith was also consulting physician to the Weymouth Royal Hospital.

NOTES.

THE following letter appeared in the April number of the 'American Journal of Obstetrics':—

THE FOUNDATION OF THE BRITISH GYNÆCOLOGICAL SOCIETY.

To the Editor of the American Journal of Obstetrics.

DEAR DR. MUNDÉ,—Since the publication of my letter to you in this Journal, Vol. XVII. No. 8, on 'The Relations between Medicine, Surgery, and Obstetrics in London,' the course of events has illustrated in a striking manner the views expressed as to the unsatisfactory nature of those relations. The main principle advocated in that letter was the necessity for achieving equality with medicine and surgery for obstetrics including gynæcology. The most flagrant mark of inferiority stamped upon obstetrics, and therefore upon those who practise it, is the subjection of the teachers of obstetrics in the great London hospitals to the surgeons, in the surgical treatment of the cases assigned to them. For example, a woman is sent into the obstetric or gynæcological ward with a pelvic or abdominal tumour. If the obstetric physician diagnose it as an ovarian cyst, his interest and his right over the case cease; he must send it the surgeon to operate. The obstetric physician is declared incompetent.

He must accept the humiliating position of seeing his patient taken from him just at the climax of clinical and therapeutical interest. I pointed out that this arrangement was bad for the patient, bad for the students, bad for the obstetric physician, and bad even for the surgeon. It exercises a distinctly demoralising influence upon the obstetric physician, obviously, since it takes away his responsibility, and limits his zeal for scientific observation; upon the surgeon, since it fosters in his mind an unjust idea of the incapacity of his colleague, and an undue estimate of his own capacity. It is ridiculous to suppose that abstract science, or its application to the relief of suffering women, can be successfully pursued when an individual case is split up into two parts or stages, one falling to the care of one man, the other to a second.

Pathology as it proceeds in a patient is a continuous evolution. The beginning must be known rightly to appreciate the middle and the end, and so it is with the converse. Nothing more painfully absurd can be imagined than the conduct of a man in giving an

opinion upon a case of pelvic or abdominal tumour, who never operates. Who would not ridicule the pretension of a man to be an anatomist who never dissected! Who would not ridicule the pretension of a man to be a surgeon, or to give a surgical opinion, who never operates!

Yet this is daily exemplified in the larger hospitals in London, namely, St. Bartholomew's, St. Thomas's, Guy's, the London, also at the Middlesex, the Westminster, and, I believe, at Charing Cross.

One great object aimed at in the foundation of the Obstetrical Society was to break down this intolerable yoke. Tyler Smith, the initiative genius of the movement, held the attainment of this aim to be a fundamental condition of the advance of gynæcological science in this country. The Obstetrical Society, he hoped, would be a powerful force in emancipating those who cultivated this science, and who are called upon to teach it, from the degrading thraldom under which they worked. It may be confidently affirmed that those who joined Tyler Smith in this movement, Alfred Meadows, Aveling, Charles Clay, Hall Davis, Graily Hewitt, Lloyd Roberts, Routh, Protheroe Smith, myself, and others were cordially with him. On the foundation of St. Mary's Hospital, Tyler Smith contended for and won the right to operate. He distinguished himself by establishing, if not by initiating, the treatment of the pedicle in ovariotomy by ligatures, and dropping it into the peritoneal cavity. No hospital surgeon can show an achievement of equal merit. Graily Hewitt, who was then assistant obstetric physician under Tyler Smith, established and practised the right to perform ovariotomy at University College Hospital.

Meadows, who succeeded Tyler Smith at St. Mary's, continues there the good work of his illustrious predecessor. From this precedent, the privilege of operating was obtained at St. George's by myself, and with me it ceases. At Guy's the privilege was conceded to the obstetric physician; but the surgeons brought their overwhelming influence to bear upon the autocrat who rules there, and the privilege was taken away. The obstetric physician had to submit to be degraded. Braxton Hicks, to whom science owes so much, had so nearly reached his term of office that, it is presumed, he did not think it incumbent upon him to hold out. His colleague and proximate successor, Dr. Galabin, with his whole career before him, was content to pass again under the surgical yoke. In vain protest he held out his hands, and—was handcuffed.

This retrograde movement, this repulse of the obstetric branch, is of bad omen. It shows unmistakably the spirit that animates the surgical branch, and—may we say it?—the weakness of those who

bow beneath the blow. I do not hesitate to say that the right to operate would be won to-morrow, if the obstetric physicians were resolute in asserting it. But whilst men are found weak enough, or politic enough, to accept and hold office under the terms imposed by the surgeons, there is little hope of establishing the principle for which Tyler Smith and others have fought and suffered.

And now, for the time at least, even the Obstetrical Society, founded to establish this principle, and in which the great hope of reform was centred, is overshadowed by adverse influences. Those who dispense patronage and favour have, in an unmistakable manner, made it felt that those who choose to emancipate themselves from the old bonds, to assert their right to cultivate gynæcology as it is cultivated elsewhere than in London, must expect to be left out in the cold. Gradually the government of the Obstetrical Society, reflecting or succumbing to the policy of the surgeons, has fallen into the hands of men who tamely abandon the great principle pronounced by its founders.

Thus we witness the curious spectacle of men in our great hospital schools teaching gynæcology in handcuffs. Nor is this passive abandonment of their own claims the only ground of reproach. Every man, if he does not assume a representative position, may, with some show of reason, claim to be the best judge of his own capacity and of his own interest. If he does not feel himself competent to operate, or is willing, from other personal reasons, to forego the right, he may be accorded all the respect that is due to modesty. If it be urged, as it unfortunately may be urged, that with men in this negative position are united others who do operate in general hospitals, the impeachment is not lightened. These men might remember that the privilege they enjoy was not won by themselves or at their own cost. It is the direct result of the work and example of the founders of the Obstetrical Society.

We may understand, even if we cannot esteem, the action of those who do not operate; they may be supposed to be convinced that others should not be permitted to do that which they themselves are unwilling or incompetent to do. The fox who had lost his tail had policy on his side in trying to persuade his fellows that it was wrong to wear a tail. But in a conclave of properly endowed foxes, what would be thought of those who should try to maim their fellows? Yet this is the course adopted by some of those school-hospital physicians to whom the right to operate has fallen. They practically, if not in words, deny the right of others to operate in special gynæcological hospitals. With astounding obtuseness they fail to see that the assertion of the right to operate can best be secured

to themselves by the very men whom they discourage. These special hospitals of gynæcology, like the ophthalmic hospitals, have sprung up as active protests against the tyrannous monopoly of the school-hospitals. It is in these hospitals alone that gynæcology can be pursued with that perfect freedom which is the life of scientific progress. Just as the ophthalmic hospitals served as engines to force the doors of the school-hospitals, compelling them to admit ophthalmic surgeons with the right to operate, so it is obvious that the hope of achieving full rights for the obstetric physicians of the general hospitals must rest upon the special gynæcological hospitals. The pressure must come from without. And, unless that pressure be kept up, it is not difficult to see, from what is now going on, that what has been gained in two or three general hospitals is in imminent danger of being lost. Witness Guy's! St. George's is already doomed. University and King's Colleges, St. Mary's, will probably share the same fate.

If the obstetric physicians of University and King's Colleges contend that the right to operate is vindicated in their persons, it may be useful to remind them how invidious is the position they occupy. If their conduct be short-sighted as regards their own interests, it is ungenerous and unjust towards those who have found a field for themselves in special hospitals. The monopoly they seek to construct, on the ground that they have gained admission to general hospitals, cannot be justified by superior merit. Aveling alone has done at least as much for clinical and operative obstetrics and gynæcology, and for obstetric literature very much more than any one of them. Fortunately perhaps for himself, and certainly fortunately for science, he has found a free field for the exercise of his talents. And what shall be said of Lawson Tait, who has shed such lustre upon British gynæcology? He happily is not crippled by the narrow prejudices and antiquated rules of the London schools.

The party, which has for a time succeeded in diverting the Obstetrical Society from its original purpose, has in the most decisive manner marked its policy by nominating for President, not Drs. Meadows, Aveling, Routh, original Fellows who have done the Society and science some service, but Dr. Potter, who represents—well, the views of those who nominate him; that is, the negation of the principles which the Society was founded to foster.

This act, so injurious to those whose just claims of seniority and of work have been passed over, has been accepted as the best proof that gynæcology must seek an independent field for cultivation. It has long been felt that the Obstetrical Society did not offer sufficient scope and freedom for the study of gynæcology. In fact, it is only

necessary to glance at the comparative positions attained by this science in Britain and in America, and even in the English provinces, to realise how difficult is progress here, oppressed by the dead weight of the old corporations, of the general hospitals, and the discouragement it meets with in the Obstetrical Society.

The British Gynæcological Society, then, has been founded: 1. To revive and to assert the fundamental principle which animated the founders of the Obstetrical Society, namely, equality for the obstetric branch with the medical and surgical branches, including the independent right to carry through the clinical study of obstetric and gynæcological cases even to operation. 2. To afford a free and open field for the discussion of gynæcological subjects. 3. To utilise the clinical material, and to strengthen the position of the physicians of the special gynæcological hospitals. 4. To give due acknowledgment and honour to those men who, by long service and original work, deserve well of their associates, and who have made a reputation beyond the council-room of the Obstetrical Society.

The deliberate neglect of the claims of the seniors whose names would have been hailed as fit representatives of British obstetrics and gynæcology, in favour of one whose claim has yet to be established, must surely provoke the question: What does it mean? Who benefits by this flagrant act of injustice? Was there any adequate reason for passing them over? If there be, those who are responsible for this act have not ventured to state it. It was settled by a brutal vote. They might have recognised the propriety of nominating one of their distinguished provincial Fellows. But this, it appears, did not fall in with their policy. We are free, then, to ask what this policy is. If we cannot in distinct terms define it, we may judge of it by the obvious consequences. By excluding the seniors of the Society, the younger men come in before their due time for the honours those seniors have deserved. And this usurpation, for it is nothing less, is to be achieved by the deliberate sacrifice of the fundamental principles of the Society.

It is a significant fact, strangely confirmatory of this view, that the retiring President, Dr. Gervis, in his address, discreetly avoided all reference to these principles, all attempt at justification of the action of the Council. A bare summary of the papers read, biographical notices of the Fellows lost by death, make up the address.

The address is remarkable for what is not in it. It might even be said that the obituary is not complete. As far as the action of the Society is concerned, the principles which gave the Society birth are dead.

But these principles, the principles of truth, will assuredly not die. They will enter into the life of the British Gynæcological Society. Under the wholesome influence of example, there is good hope that even the Obstetrical Society will revise its actions, and revert to a more liberal policy. At any rate, science will benefit. The subjects of obstetrics and gynæcology are too vast, and too rapidly growing, gynæcology especially, to be adequately represented and cultivated in one Society. Gynæcological societies flourish in America and in Germany. In this country, so rich in clinical material, there is ample scope.

Under these conditions, then, the British Gynæcological Society starts. It will hold its inaugural meeting under the presidency of Dr. Meadows, with more than two hundred foundation Fellows; with a liberal constitution, a body of active and zealous workers. Oppressed by no class prejudices or artificial disabilities, it bids fair to prosper, and to raise the repute of British gynæcology.

ROBERT BARNES.

15 Harley Street, London:
February 1885.

The following letter has been received in answer to the application, from the Council of the British Gynæcological Society to the Council of the British Medical Association, in which the formation of a gynæcological section was suggested at the annual meeting of the Association:

British Medical Association, 14 Temple Row, Birmingham,
April 18, 1885.

My dear Sir,—The Council of the British Medical Association duly considered the memorial of the British Gynæcological Society at their last meeting, and passed the following resolution:

'That the President of the Council be requested to write stating that it is too late to alter the arrangements for this year, but that it is a matter which may be considered next year.'

You will gather from this that the proposal contained in your memorial was received in a very friendly spirit, but the fact that the Section of Obstetric Medicine had been constituted for some months, and its officers appointed, induced the Council to consider it undesirable to make any alterations this year in the constitution and functions of the section and its officers. I am, yours very truly.

BALTHAZAR FOSTER.

To Alfred Meadows, Esq. M.D.
President British Gynæcological Society.

At the last meeting of the Council of the British Gynæcological Society, a Committee consisting of Drs. Barnes, Aveling, Edis, Ban-

tock, the President, and the secretaries, with power to add to their number, was appointed to collect evidence and report upon, within twelve months, the subject of menstruation. The Council voted a grant of 50*l.* towards the laboratory and other expenses incidental to the investigation.

The President of the British Gynæcological Society, Dr. Meadows, gave a brilliant and successful conversazione on May 12 to the Fellows of the Society. The conversazione was held in the Marlborough Rooms. A large and influential company assembled, including representatives from every branch of the profession. There were many Fellows of the Society present from the provinces, among whom we noted Dr. Sinclair Coghill (Ventnor), Mr. Lawson Tait (Birmingham), and Mr. Vincent Jackson (Wolverhampton). Among the metropolitan Fellows and visitors were Dr. Barnes, Dr. Broadbent, Dr. Ord, Sir William MacCormac, Dr. Quain, Dr. Godson, Dr. Graily Hewitt, Dr. Protheroe Smith, Dr. Aveling, Mr. Reeves, Mr. Malcolm Morris, Mr. Cowell, Mr. T. Nunn, Professor Bell Pettigrew, and Dr. Crichton Browne. The various rooms were filled with works of art, pictures, and scientific apparatus. There was a large and interesting display of gynæcological instruments by Messrs. Mayer and Meltzler, and Krohne and Sesemann. Messrs. Squire and Corbyn also exhibited an interesting collection of special drugs. Drs. Routh, Propert, Aveling, Heywood Smith, Bantock, and others lent various *objets d'art* and specimens. Dr. Meadows showed a magnificent collection of specimens under the microscope, illustrating ovulation, the structure of the uterus, ovaries, and placenta. An interesting contribution of ancient Japanese arms and metal work, and of captured arms from Suakin, was lent by Mr. Ernest Hart. The proceedings were enlivened throughout the evening by the excellent playing of the Coldstream Guards band, which went far to secure the success of a most pleasant and enjoyable gathering.

The Hospital for Women.

The Duke of Westminster presided over an influential meeting held on Saturday afternoon, June 6, at Grosvenor House, in support of an appeal which is being made to obtain funds to enlarge this hospital. There was a numerous attendance, which included the Duchess of Westminster, Earl Sydney, the Earl of Aberdeen, Sir Farrer Herschell, Q.C., M.P., Sir Rutherford Alcock, the Bishop of Derry, General Higginson, and Sir Montague Smith. The appeal, which is signed by Princess Christian of Schleswig-Holstein, as President of the Ladies' Committee, is addressed to the women of the United King-

dom. To obtain the enlargement of the hospital buildings, which is absolutely necessary, the general committees estimate that not less than 100,000*l.* will be required. The Chairman, in opening the proceedings, said that there was an objection on the part of very many to what were called special hospitals, and no doubt a very great deal could be said against them; but hospitals for women scarcely came under that denomination. During the forty-three years that the hospital had been at work it had done an immense amount of good in the cure of diseases to which women were liable. The Earl of Aberdeen moved and the Bishop of Derry seconded the first resolution, which was as follows: 'That this meeting, recognising the great claims of the hospital to increased public support and the urgent necessity for its enlargement, hereby pledges itself by every means in its power to promote the appeal for this object.' Dr. Protheroe Smith, the founder of the hospital, supported the motion, which was agreed to. Sir Rutherford Alcock next moved: 'That this meeting desires to offer its grateful thanks to Her Royal Highness Princess Christian of Schleswig-Holstein and the Ladies' Committee, for their sanction and support of the appeal to the women of the United Kingdom.' He said that the mere fact that they had had under treatment 100,000 patients, and that more than 7,000 of those had been treated in the wards of the hospital, was quite sufficient proof that it had conferred a great benefit on the womanhood of not only the metropolis, but of all parts of the world. Therefore, the institution was a national one. Sir Farrer Herschell, Q.C., M.P., in seconding the motion, said that a hospital for women was one of the charities most loudly calling for the sympathies both of men and women. The motion having been carried, a vote of thanks was accorded to the Duke of Westminster.

We deeply regret to have to record the death, at the early age of fifty-one, of Dr. John Thorburn, Professor of Obstetrics at Owens College, Manchester. Dr. Thorburn was well known as a gynæcologist, and occupied a leading position as a practitioner in Manchester. He had just published a 'Practical Treatise on the Diseases of Women,' a review of which will be found at page 213 of this number of the Journal.

At the meeting of the British Gynæcological Society on June 10th Dr. Alexander of Liverpool read an interesting paper on his operation of shortening the round ligaments in uterine displacements. Among the visitors on this occasion were Professor Tibone of Turin, and Dr. Calderini of Parma.

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INGLUVIN

IN CASES OF DIARRHŒA, CHOLERA INFANTUM, & MARASMUS

The prevalence of Cholera Infantum, Cholera Morbus, and Diarrhœa, to a greater extent i the summer period, induces us to call the attention of the medical fraternity to the late introduced remedy 'INGLUVIN.' It has been used in practice with very happy results for considerable time. We find Indigestion generally at the bottom of bowel complaints, whic INGLUVIN has almost instantly corrected alone or in combination. It is given in the followin formulas with great advantage:

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Misce et Ft. cht. No. x.		Misce et Ft. cht. No. xii.	
Sig.—One every 4 hours.	Misce. Sig.—A teaspoonful every 2 to 4 hours.	Sig.—One every 4 to 6 hours.	Misce. Sig. — Dessert spoonful every 2 or hours, or after eac evacuation.

In inflammatory affections, INGLUVIN is combined with Subnitrate of Bismuth, equa parts, and oleaginous mixtures with Ol. Terebinth, instead of Aqua Calcis. Should th evacuations be suddenly arrested, and tympanites supervene, follow with a dose of oil o magnesia, or injections. In many cases of sick headache and indigestion, the most happ results follow from the combining of INGLUVIN with Pv. Nux Vomica, the one-twentieth t one-tenth grain.

Marasmus successfully treated with INGLUVIN.—See Article below.

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Dear Sirs,—Will you have the kindness to inform me if you have an agent in this town for WARNER'S INGLUVIN, as I shall most likely prescribe it from time to time, in order to give it a more extended trial I was much gratified with its action in a distressing case of Tabeo-Mesenteric Disease. I had no difficulty in bringing the pain under subjection by opiates, &c.; but in the vomiting, emaciation, and disordered condition of the bowels, there was no improvement. Finding a sample box of INGLUVIN upon my consulting table (and for which accept my thanks, for I firmly believe that the powder saved my little patient's life), I gave the mother the box containing a dozen powders, requesting her to divide one into three, and administer one twice daily. The pain disappeared, the vomiting ceased, flesh was rapidly put on, and in the short space of a fortnight the patient (previously under treatment for six weeks) was convalescent and completely recovered (aged 2½ years).

Believe me, yours faithfully,

ANTHONY BELL, L.R.C.P.Ed., M.R.C.S.Eng., L.S.A., &c.
Late Senior Assistant to the Newcastle Infirmary, and Surgeon to the Hospital for Diseases of the Skin, &c.

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GYNÆCOLOGICAL JOURNAL

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THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, JUNE 10th, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 24 Fellows, 9 Visitors. The following gentlemen were elected Fellows of the Society:—Dr. W. Armstrong, Dr. J. W. Byers, Dr. Henry Blake, Dr. D. A. D'Monte, Dr. Peter Giles, Dr. C. H. Joubert, Dr. W. Whitla, Dr. W. J. Sinclair.

The following gentlemen were proposed for election:—Dr. R. C. M. Pooley, Falmouth; Dr. E. S. Stevenson, Cape of Good Hope; Dr. J. H. Allden, Southampton; Dr. J. W. D. Hooper, Melbourne; Dr. F. W. Strange, Toronto; Dr. H. L. Smith, Nottingham; Dr. G. H. Darwin, Manchester; Dr. J. J. Macan, London; Mr. J. B. Sutton, London; Dr. J. T. O'Donnell, London.

Dr. ARTHUR W. EDIS showed a new needle-holder designed by Mr. A. E. Nevins (a student at the Middlesex Hospital), for use with Hagedorn's needles in operations for vesico-vaginal fistula. Dr. Edis explained that the advantages claimed for this instrument over Hagedorn's needle-

holder were: (1st) That by substituting a thin round handle for a forceps handle the view into the vagina is less obstructed by the operator's hand, and there is more room left for manipulation.

(2nd) That the needle is more firmly grasped, being held by a screw clamp instead of by a lever mechanism.

(3rd) That the needle having been passed into the tissues is more easily released, that movement being effected in the new instrument by pressing on a button, which is close to the tip of the thumb.

Dr. AVELING said: I have had considerable experience with fistulæ, and I have come to the conclusion that the simpler the instruments employed the better. For my part I use a curved needle with stem all in one piece. I think if operators would give their minds to simplifying instruments instead of complicating them it would be more advantageous. It is very easy to complicate and make instruments like that, but as far as I can see—I have not examined it carefully—it will only hold the needle at right angles. Then in some instances, where you require to have the wound stitched longitudinally, it would be impossible to use that instrument. Besides, it is an unnecessary complication, I can assure Fellows from the experience I have had. A simple needle in one piece is all that is necessary in the most difficult cases.

Mr. LAWSON TAIT. I should like to confirm Dr. Edis' statement. I can commend the needle-holder as a very clever piece of mechanical ingenuity. What I want to condemn is Hagedorn's needles, which I think are the most barbarous things ever brought before the surgical profession. If there is anything you want to avoid in a needle it is a cutting surface.

Here is a needle two inches long that has a quarter of an inch cutting surface. I would sooner do anything than use a needle like that. I bought a set of these needles, and I have stuck them up against the wall as things to be avoided.

Dr. BANTOCK was unable to agree with Mr. Lawson Tait in his condemnation of Hagedorn's needles. Having

been the first to use them in this country, and having had considerable experience of them, he was able to express his unqualified approval of them. With regard, however, to the new needle-holder which had been exhibited, his opinion went the other way. It was complicated and difficult to use, and the only thing to recommend it was its extra length, which need not be a peculiarity.

Dr. MEADOWS. I should like to say one or two words, as I think the question of instruments is one deserving attention. I quite concur with Dr. Aveling as to the great importance of making our instruments as simple as we can. I have had a large number of fistula cases, and the needle which I most frequently use is the tubular needle. They have a number of notches, by which you can fix them in a handle, and when fixed they are as firm as if they were one instrument; and we have a number of them, and they can be used straight and parallel with the instrument or at any angle you like. Being of the tubular kind, when you have inserted your needle for the most difficult part, the application of the ligatures is very easy, and I think the success of the operation is almost absolutely assured. I constantly use these needles, as when you have your needle through, you have your ligature through also.

Another point of very great importance is the use of the sutures with a spiral coil. I believe I am right in saying that the credit of this belongs to Dr. Aveling, and I think it is one of the greatest improvements in the operation of vesico-vaginal fistula. It simplifies the removal of the sutures at the end of the week or fortnight. The difficulty of moving the sutures is sometimes very great, and you are apt to cut the ligatures. By Dr. Aveling's method all that is avoided. You cut the shot off, the coil is removed, and there is no difficulty at all about it.

I would certainly say that the tubular needle is preferable to this or any other needle that I have seen.

Dr. R. T. SMITH showed a large multilocular ovarian tumour taken from a patient who had died from cerebral

apoplexy. All arrangements had been made for the operation of ovariotomy two days preceding her death, when on calling in the hospital he learnt she had suddenly lost consciousness, and found her in a comatose condition from which she never rallied.

The patient was thirty years of age, had been married twelve years, and had two children. She had noticed the enlargement of the abdomen for two years, and had been informed in the first year that she was pregnant. Menstruation, however, was regular during the whole time and had become profuse of late; the tumour growing much more rapidly within the last six months, and now measuring forty-seven inches at the umbilicus. The diagnosis between ovarian tumour and a fibro-cystic tumour of the uterus was somewhat uncertain, the rapidity of the growth suggesting the former, the menorrhagia the latter.

Five months ago she had had an attack of rheumatism. On admission there was considerable anasarca of the legs and abdomen, with slight lividity of the face and extremities, but all this subsided with rest and general treatment, and the patient seemed to be in very fair condition for the operation.

Pathologist's Report.—The tumour is a large multilocular ovarian cyst; very hard in some portions. It was attached but slightly to the transverse colon, and by a broad firm band four inches wide very closely to the uterus. Its removal would have been comparatively easy.

Brain.—Veins very distended—no lymph on surface. A patch of softening was found in the region of the Island of Reil and external capsule on the left side. The patch was pale, broke down readily under the finger, and the detritus was easily washed away by a stream of water.

No hæmorrhagic clot was present. A thrombus about half an inch long was found in the left middle cerebral artery, the central portion being embolic in structure. The edges of the mitral valve were studded with soft granulations.

Dr. EDIS spoke as to the importance of making a correct diagnosis. In the present case pregnancy, ovarian tumour, and fibro-cystic uterus had each been diagnosed.

Dr. BANTOCK exhibited a fibroid tumour which he had removed on the 4th inst. by supra-vaginal hysterectomy from a single woman aged about 40 years. The patient had been cognisant of it for about two years. Last year she entered the Rotunda Hospital, Dublin, on account of excessive menstruation. There she was treated by subcutaneous injections of ergot with the results—either as sequence or consequence—that the flow was reduced to a moderate amount, but that hysteria became developed to a marked degree. It was exceedingly difficult to determine the question of operation. He was unable to urge it, as the patient was not then suffering any special inconvenience, but he advised it as the tumour appeared to be growing. Nor was the question finally settled until the patient was on the table. Fortunately she yielded to the gentlest persuasion; for the tumour, which was an example of the intra-neural form, with enormously thickened walls, had already undergone extensive cystiform degeneration. The right ovary, which had to be ligatured separately, was as large as a hen's egg and presented an example of early celloid degeneration. He was happy to add that the patient was progressing satisfactorily in her convalescence.

Dr. BANTOCK also exhibited the ovaries and tubes which he had removed in the afternoon from a married woman aged 33. She had suffered from severe pain for about two years, and was unfit to discharge her household duties. There was very little to be discovered on examination, and he undertook the operation at the special request of the patient. The omentum was most intimately adherent to the parietes in the line of incision, and he had to go through it to get into the peritoneal cavity. On the left side the ovary and tube were blended together by adhesions, and there was also a thick fleshy adhesion to the sigmoid flexure. This was transfixed and tied in two portions, and division effected by scissors on the ovarian side. Then the ovary and portion of the tube were ligatured in his usual way with a fig. 8 ligature. In this case the ovary was atrophied and the tube blocked. On the right side the ovary was as large as a bantam's egg

and cystic; the tube was partly blocked and cord-like, and partly sacculated with puriform contents—in very small quantity. This condition of the tubes was evidently the result of a preceding salpingitis. In closing the abdominal wound it was impossible to find the peritoneal edges until a portion of the omentum had been separated and removed after applying ligatures.

Dr. ROUTH. Can Dr. Bantock say whether there was really nothing in the shape of gonorrhœa present or endometritis? I am particularly anxious to have that question answered. If he has not any information, I wish he would get it.

Mr. LAWSON TAIT said: It is most difficult to get information on the point, and I may illustrate that by a case in which I operated three or four years since, and it is only three weeks ago that at last she confessed to me that she had had gonorrhœa, although she knew perfectly well before that she had a bad gonorrhœa given her by her husband. She had known this six years, and had refrained from giving me the information, although questioned carefully.

The Operation of correcting some Uterine Displacements by shortening the Round Ligaments. By WILLIAM ALEXANDER, M.D., F.R.C.S., Visiting Surgeon, Liverpool Workhouse Hospital.

Mr. President and Gentlemen,—I have very much pleasure in reading a paper upon the operation of shortening the round ligament before the members of this society, for two reasons. First. I can expect from such an assembly of specialists more intelligent appreciation of the operation, its principles and results, than I could expect from a mixed society containing only one or two professed gynæcologists. Second. If I can induce any of its celebrated members to adopt the operation, such a result would be far more important to the popularising of shortening the round ligament than reams of paper printed on the subject by an obscure individual like myself. The

nk and file of the profession largely follow their acknowdged leaders, and had the operation been contrived or advoated by any one of several whom I see around me it would ave been adopted in every hospital in Great Britain long ago. t says a good deal for the value of the operation itself, that, orn as it was in a lowly place—a workhouse, in fact—it has, espite its pauper birth, been now performed in nearly all the rominent cities in the world and by most operators with ore uniform success than generally befalls any new operation.

Without further preface I will plunge at once *in medias res.* I am under the impression that practical directions as to the mode of performing the operation will interest you most, and to these I first address myself. Then I will explain to you the principles upon which I think the success of the operation depends; and lastly I will give you the result of the operation during the three and a half years I have been performing it. Some remarks upon the mode of performing the operation are specially opportune at the present time, for in the 'New England Medical Monthly' Dr. Paul F. Mundé describes four cases where he attempted the round ligament operation. In one he was perfectly successful, in the second he could only with great difficulty get one ligament, and in the third and fourth he could not find any ligaments at all. In the second case there was so much suppuration that no useful result followed the operation. He draws the following conclusions.

1. That Alexander's operation is chiefly indicated, because most feasible, in thin, spare women, with very little abdominal adiposity, in whom the pubic spines and the pillars of the external inguinal rings can readily be detected by palpation.

2. That in stout women the adipose tissue in the inguinal ring so obscures the terminal fibres of the round ligaments as to render their recognition and isolation a very difficult or impossible feat.

3. That in some women, both stout (especially so) and spare, the ligaments are deficient in the white tendinous sheen which renders them easily recognisable, are, therefore, wholly muscular, and when isolated are very liable to break in the depth of the inguinal canal when drawn upon, and thus invalidate the operation even before it is concluded.

4. That it is impossible to know beforehand in which women the ligaments are normal in composition and insertion, and that, therefore, this operation must always carry with it an element of uncertainty in its very execution, which will prevent its prognosis from ever being as assured as that of many other plastic operations.

5. That with the exception of the tendency to keep suppuration in the inguinal canal, the operation is devoid of special danger; and—

6. That in certain well-indicated cases (movable, flabby uteri, with retroversion, or retroflexion, or descensus; spare, slender women, with well-developed pubic spines and distinct external inguinal rings), the ligaments can easily be found, isolated, drawn out and shortened, and the fundus uteri permanently and satisfactorily fixed in the normal anteverted position.

Unfortunately, it is greatly a matter of chance whether the case turns out a favourable one for operation or not. In some cases, I am informed by anatomists, the round ligaments cannot be traced on the cadaver from the fundus uteri farther outwards than to the internal abdominal ring, where they become lost as separate cords. Manifestly, if in such cases it is impossible to trace the ligaments from within outward, it will be much more so in the converse direction.

In spite of the two failures reported, I shall not lose sight of the operation, for I feel that it has a certain *restricted* future, and shall attempt it again in the most favourable subject I can find.

A few weeks before, a paper verging on the opposite extreme appeared in the 'Edinburgh Medical,' where Dr. Imlach describes the results of the operation in his hands. He never failed in nearly forty cases to find the ligaments, and thinks only half an inch of an incision is all that is necessary in any case for the purposes of the operation. If Dr. Imlach minimised matters to an extent that was unsafe for the inexperienced to follow, Dr. Mundé's conclusions err far more in exaggerating the difficulties and uncertainties of the operation.

The operation is a delicate one, and quite different from nearly all the ordinary operations. It resembles most ligature of arteries or neurotomies, but from both it differs in many essential particulars. In the ligature of an artery the pulsation of the vessel guides us to the spot and assures us that we have reached the structure we seek. In looking for a nerve

we have a characteristic white structure to find, and twitching often shows us when we have found it.

The round ligament does not pulsate, and is of a pale flesh colour when first seen. It lies embedded in other tissues that by the inexperienced might easily be mistaken for it. Its white sheen only appears when pulled out.

Now when I have been told that tiros in surgery had been exasperated and disappointed at not finding the ligaments, and had anathematised myself and the operation as a cure for their disappointment, I have heard of the occurrence with equanimity and perhaps with some degree of satisfaction, and remarked that they deserved the disappointment, since they had attempted the operation without any previous preparation except reading the description in my book or in some of the medical papers. Their statements did not prejudice others against the operation, and therefore did not require much notice. The conclusions of Dr. Mundé would, if correct, almost destroy the value of the operation. If an operator could only find the round ligament in three out of every eight incisions he made, the operation would be a most uncertain one, which I would have been the first to condemn. Now I have tried to find eighty ligaments in the living subject. I failed to find one ligament in my fourth case. I closed up the wound, went on performing the operation in other cases, and after a time returned to this case, where I was able to pull out a strong substantial ligament. In two cases one ligament in each was adherent and would not pull out. In both the opposite ligament was strong, and the cases are well up to the present time. My own experience, therefore, on the living affords no corroboration of Dr. Mundé's conclusions, although many of them were very fat. Dr. Imlach has operated in thirty-six cases, and he never failed to find the ligament. In two the ligaments would not stand the pull upon them. In both I am inclined to think he may not have seized the right structure. In the dead subject I have examined the round ligament at ages ranging from a day old to sixty years in more than one hundred cases, and, except in two cases of

pelvic adhesion, where the ligaments were found but failed to run, I have never found any difficulty in finding them and pulling them out. The resident medical officers of the workhouse have practised the operation in many cases when they were engaged in making autopsies on women, and neither have they after a little practice failed to isolate the ligaments. For all these reasons I am inclined to think that the failure to find and draw out the ligaments, rests generally—I should say in ninety-nine cases out of every hundred—with the surgeon, and is not due to the variable anatomy of the parts. Dr. Mundé's conclusions are therefore very incorrect.

However, I expect I have been to blame somewhat for not detailing with sufficient minuteness the steps of the operation. It seems now to me so easy that I perhaps forget too much the many experiments I made on the dead subject before I attempted it on the living, as well as the considerable amount of practice I have had upon the living, and the personal dexterity acquired by showing it on both the living and the dead to many surgeons who were anxious to see how to do it.

I will now point out what I think the best way to make sure of finding the ligaments, but I would warn any who intend to operate, no matter what their standing, to practise it first a few times on the dead subject if they wish to avoid disappointment.

The pubic spine is the first landmark, and can be felt by an intelligent finger under any depth of superincumbent fat. It does not matter very much whether the finger can feel the spine clearly or not, provided the primary incision is made within reasonable distance of it, but there need be no serious difficulty in feeling it as Dr. Mundé seems to think. From this an incision is to be made upwards and outwards in the direction of the inguinal canal for one and a half, two or three inches according to the fatness of the subject. A considerable thickness of subcutaneous fat is now met with, which must be cut through by subsequent incisions until the pearly glistening tendon of the external oblique muscle is

reached. Midway through the fatty tissue an aponeurosis sometimes appears so firm and smooth that it may cause the operator to think he is deep enough, and if he begins to poke about here, as I have done and have seen done, it is little wonder no ligaments can there be found. The first stage of the operation consists simply in cutting down upon the tendon of the external oblique muscles until it appears clear and shining at the bottom of the wound. If the operator succeeded in hitting the spine, the external inguinal canal, with the intercolumnar fibres crossing it, can also be seen. If not, the aperture now made down to the muscles can be dragged over an extensive area by retractors, so that the region can be searched until the ring is found. The finger, passed to the bottom of the wound, may be used to detect the spine and the ring outside; the former by its hardness, and the latter by its lessened resistance compared with that of the aponeurosis around it. The anatomical knowledge of the operator should always be equal to the recognition of these structures, that is the spine and the external abdominal ring. There are other apertures, as the aponeurosis and a depression filled with fat below Poupart's ligament, that sometimes simulate the external ring. Poupart's ligament below, the intercolumnar fascia running across, and the spine at the inner side are sufficient landmarks. When in doubt, a slow deliberate survey of the position should be taken, and no gropings in the dark made, as these are certain to lead to failure.

Having clearly isolated the external abdominal wound, and tied or compressed any little vessels necessary to be attended to, the next step in the operation may be entered upon, viz. to find the end of the ligament. The intercolumnar fascia, which is generally pushed forwards by the fat and other structures beneath, is to be cut through over all the extent of the external ring and in the direction of its longest diameter: a nerve, some vessels, fat, some tendinous bands, and the round ligament spring out of the canal immediately. In fat people the quantity of fat conceals all the other structures. No 'grabbing' at the mass is now to be practised, as some

have recommended. By everting all the structures upwards the round ligament can be seen generally at the lowest part, and with the white easily distinguished genital branch of the genito-crural nerve along its anterior surface and close to it. The ligament at this stage is more or less rounded in shape, sometimes rather delicate, but an always easily recognised flesh-coloured structure that might be easily destroyed by forceps rudely and blindly applied. Should the ligament seem very frail, or the operator be doubtful whether he has found it or not, he should take care not to displace the structures, or to destroy them by searching or pulling. His best plan in such a case is to open up the inguinal canal a little, and then re-examine what he supposes to be the ligament. No difficulty in finding the ligament need thus ever be experienced, provided the operator knows what he is about: when the ligament is clearly identified the small nerve on its surface is to be cut through without cutting any of the ligament. Then gentle traction is to be made either by the fingers or broad blunt-pointed forceps. Care must be taken not to break the ligament by such traction. Bands will now be seen holding it to the neighbouring structures. These should be cut through with scissors, the greatest caution being used to avoid notching the ligament itself at the same time. With a little patience and perseverance the structure is so far free that all resistance is at an end, and it comes out as easily as if broken inside, as Dr. Mundé thought it was in his first case.

As soon as it begins to 'peel' out, and without drawing it out farther, I leave that side after covering the wound with a clean sponge and operate on the opposite side. To do so my assistant and I change sides, so that I always stand on the side opposite to that on which I am operating. I can look thus better into the canal and draw the ligament more conveniently towards me, but of course the operation could be performed without this change of position.

Having freed the opposite ligament, the difficulties of the operation are at an end, and the second stage is finished.

The structures that I have mistaken for the ligament in my early operations were bands of fascia, the nerve, and especially fasciculi of the internal oblique muscle. The latter are very like it, are very brittle, and I have no doubt have been the frail fatty degenerated ligaments that some operators have found but could not pull out. They seem to go along the canal in the direction of the ligaments. They should never be seen when the operation is satisfactorily performed. I cannot on paper give with advantage a more detailed description of how to perform the second stage. It must be seen to be thoroughly understood.

The third stage consists in placing the uterus in position by the sound, and pulling out the ligaments until they are felt to control that position. The replacing of the uterus is first performed, and is held in position by a third assistant. The operator pulls out both ligaments almost simultaneously and gently until the sound is felt to be slightly moved. He then hands both to the first assistant to hold while with a curved needle threaded with moderately fine catgut he stitches each to both pillars of the ring by two sutures on each side, and thus secures the closure of the external abdominal ring and the fixation of the ligament without injuriously strangling the latter structure as it lies between. The assistant can now let go, the chafed ends of the ligaments are cut off, and the remainder stitched into the wound by means of the sutures that close the incision. A fine drainage tube is inserted, and the wound washed out with carbolic or other lotion before these sutures are tied. The conditions under which the operation is performed and the dressing now to be applied may vary with the bias of the operator. In hospital I perform the operation under the spray and use the gauze dressings; in private I dispense with the spray, and sometimes use boracic lint or absorbent cotton wool. I always drain, as I believe it to be so much safer, preventing any collection of pus or danger of interfascial suppuration. It may retard, in some cases, the healing of the wound, but as I never allow my patients out of bed under three weeks, this is not of much importance.

Before the dressing is applied in simple cases of retroversion and a prolapse, I insert a Hodge's pessary and keep it in at least during the convalescence. When there is retroflexion as well, I always insert a galvanic stem to keep the uterus straight during the healing of the wound. This I look upon as essential, because not only has the uterus gained a power of recoil backwards in such cases, but the attachment of the round ligaments to the uterus is displaced downwards towards the cervix, so that they do not control the tendency to recoil. This displacement of the attachment of the ligaments may occur in either or both of two ways—viz. by the abnormal enlargement of the fundus so that it grows away from the ligaments, or from the ligaments acquiring a new attachment to the body of the uterus through their long application thereto. By keeping the uterus straight the fundus either shrinks or the ligaments let go their new attachments, and resume the old. At any rate, by keeping the stem in for a month or so the cure may be with certainty effected. The time the stem must be kept in must depend on the obstinacy of the case. My object has always been to cure the patient rather than to test certain points, but I have taken it out at the end of a month and had to resume it owing to a recoil for another month. In most cases a month has been quite sufficient. Besides, a stem and Hodge that could not be retained before operation without constant displacement or distress, can always be worn indefinitely after operation without any knowledge that such instruments are inside. Some of my patients have been surprised when I removed these instruments, as from their previous experience they were sure none could be retained by them without their knowledge.

An important question with regard to the third stage of the operation is, How far are the ligaments to be pulled out? My reply is, To put the uterus in position and pull out the slack. After the ligaments have been freed they come out readily for a certain distance, and then decided resistance is felt accompanied by movement of the replaced uterus. Any

further traction pulls up the broad ligaments and the uterus, and finally is met by the resistance of the opposite ligament till the uterus is elevated to the abdominal wall. Now this lifting of the uterus is an unnatural procedure. That organ never hangs suspended under any normal conditions, and to suspend it by the ligaments must lead to failure. All we can do is to replace the uterus in its normal position, and this occurs generally when the decided check upon the pulling out of the ligaments takes place. Sometimes, but rarely, a false check occurs, but this can only be known by experience, and by care and caution can be overcome. Again, if the uterus is placed in too upright a position by excessive traction on the round ligaments these will probably gradually yield or fail to unite properly, and slight anteversion may occur. In some of my cases I have noticed a tendency to this, but it has never yet given any trouble.

The after-treatment of the operation consists in rest. The wound I generally dress on the second day, when I remove the tubes, the small aperture left where they were removed being sufficient to maintain the necessary drain in most cases. The ligaments should be allowed time to unite to the wound, to the pillars of the ring, to the canal; and for this purpose three weeks is quite short enough time. Several of my private patients have taken a longer rest, and with benefit, as thus all the pelvic organs have become accustomed to their new position. The rest need not be in bed—a sofa and the sitting posture may vary the monotony of lying in bed, whilst sewing, reading, and other feminine arts may be indulged in after the first few days.

The Anatomical and Physiological Basis of the Operation.—A short account of the principles upon which the operation depends will help to explain the proceedings described above. The most cursory examination of the pelvis of a cadaver suffices to show that neither the round ligaments nor the broad, singly or in combination, of themselves maintain the uterus in position. With the hand the fundus uteri can be retroflexed or retroverted or even expelled through the pelvic outlet

without any effectual restraining influence from these structures. In fact, in the majority of cadavers the uterus falls back by its own weight when the intestines are removed from the pelvis.

The forces that seem to keep the uterus in position are, first of all, the insertion of the cervix into a strong fibrous investment, by which that part of the organ is firmly fixed in the posterior part of the pelvis. In the second place, the upright position of the uterus is maintained, not only by the consistency of the uterus itself, but chiefly by the connection with the broad and round ligaments. The uterus and the broad ligaments form a barrier right across the pelvis, thus dividing that cavity into two compartments, one containing the rectum and the other the bladder, and both containing some coils of the small intestines. The greatest mass of the small intestines gets behind the uterus and the broad ligaments, and so effectually supports the pelvic barrier from behind.

The round ligaments, although so loosely disposed, probably assist in maintaining the upright and forward position of the broad ligaments and the uterus. The anteverted position is guarded against by the bladder and the symphysis, both of which offer very efficient support. The uterus floats upright in the pelvis of the cadaver, and is so supported by the intrapelvic forces that there is no tendency under ordinary circumstances to displacement. When from extraordinary circumstances the uterus becomes displaced, the relation of the uterus to neighbouring structures and to surrounding forces becomes entirely changed. These extraordinary circumstances may be: a want of consistence of the uterine tissue, a top-heavy uterus, a sudden dislocation of the uterus and its broad ligaments through an awkward strain, or from some ovarian or inflammatory influence. Once the uterus is down, the intestines, that formerly supported it when in position, tend, by just the same force, to keep it down. The uterus may be so resilient as to shrink back into position, but it evidently fails in many cases, and this failure is owing to the weight of the superincumbent intestinal mass, not only upon its anterior

surface but on the anterior surface of the contiguous retroverted broad ligaments. The same intestinal mass that under ordinary circumstances lay behind the uterus and the ligaments and kept it in position, now uses its influence to keep them down. In recent cases most backward displacements of the kind above alluded to could be cured by the timely aid of suitable pessaries. But when seen the broad ligaments have got inclined downwards and lengthened by the gradual pressure of the intestines; and although we may in such cases cause the uterus to resume its position by a sound, and to maintain it by a stem pessary, we cannot at the same time re-erect the broad ligaments that still keep their backward bias, and offer a surface for pressure deficient to drag the uterus back immediately the stem is removed, or to give some distress by constant tension upon the uterus when the stem is in position. By shortening the round ligaments, the uterus is not only pulled into position, but the broad ligaments are also pulled forward towards the pubes. The intestines get in behind, and no vantage ground is left for any force that would tend to bend down any part of the pelvic barrier that contains the uterus in its centre. In cases of retroflexion of the uterus, where the fundus uteri recoils uninfluenced by the tension of the round ligaments, it will at once be evident that in such cases we have left a weak point where the intestines will unhinge with tremendous force, and certainly lead to failure unless something is done. A stem pessary that corrects the flexion until any tendency to it disappears, at once obviates the difficulty and guarantees success. Another cause of backward uterine displacements, as well as of prolapse, is a yielding or laxity of the cervical uterine supports. It is manifest that if the cervix slips downwards the same effect is produced as if the fundus inclined backwards. In such cases the uterus becomes a wedge inserted as it were in the vaginal canal, and driven towards the outlet by all the force of the mobile pelvic contents. Retroversion and prolapse are the diseases so produced. If in such cases we counterbalance the stepping forwards of the cervix by an increased forward position of the fundus, we can

at once maintain the normal position of the uterus at right angles to the vagina, and so correct the tendency to retroversion and prolapse.

In still worse cases, where the rectum, uterus, and bladder are struggling for precedence in emerging from the pelvic outlet during straining, where the lower uterine supports are almost gone, or so lax as to be useless, it is manifest that we cannot moor all these organs in position by the round ligaments. A cable would be required for such a purpose. We can, however, moor the uterus behind the pubes, and thus take away its wedge-like action. Unless it were possible to restore the cervical attachment it is impossible to cure the cystocele and rectocele. By a light and suitable vaginal pessary these can often be relieved completely after operation, because the uterus is now maintained at right angles to the vagina, and much less force has to be resisted by the pessary than formerly.

There are, last of all, cases where the perineum, as well as the abdominal walls, is stretched to an inordinate extent by excessive distension of the bowels, and by the growth of mesenteric and omental fat. In such the protrusion of the uterus is a small part of the general tendency to hernia everywhere. I have not ascertained the principles upon which a radical cure of such cases can be effected.

Results of the Operation.—Unless the results of an operation are good from a practical point of view, it matters little whether its principles are apparently sound or its performance easy.

The results of an operation may be estimated in two ways:

1. By the mortality due to the operation itself.

2. By the beneficial results that accrue by its performance to those who survive.

As to the first consideration, viz. the mortality, that may be set down as *nil*. Some cases have occurred. I know of three, but all of these occurred through entirely preventible causes. One of these occurred lately in my own hospital

practice, where I operated on a dissolute prostitute. After the second day I did not pay much attention to the case, as she then seemed quite well. The nurse reported to me for several days after that she was doing nicely and that her temperature was normal. I happened to notice one day when I was about to pass her that she did not look well. We undid the dressings and found the wounds bagging, and the patient pyæmic. The nurse had been attending a patient with diffuse pyæmic scrofulous abscess, and had evidently carried the infection to this case. In spite of free opening of the wounds, fresh air and stimulation, she died of pneumonia of a purulent or pyæmic kind. At the post-mortem the ligaments were soundly attached in position, and the uterus, broad ligaments, and ovaries well pulled forwards, as I have described. This poor woman died because I had become quite confident of the smallness of the risks such operative cases ran, and because the hospital was then full of more serious operative cases that taxed all my time and strength to attend to.

The other two cases were somewhat similar in nature; one is mentioned by Dr. Mundé as occurring in the hands of a New York surgeon, and the third occurred in the practice of a Liverpool surgeon. I think it right to mention these cases here to show that the operation is not to be played with. By ordinary care, skill, and experience in operating, no fears need be entertained of a fatal result. The peritoneum lies close at hand, but surgeons who can perform the radical cure of hernia with impunity are not likely to have worse results with this operation, which is a much minor one to herniotomy.

As mortality does not seriously enter into any consideration of the results of this operation, the real question at issue is, whether it fulfils the intentions of the operator and satisfies the expectation of the patient.

Here an important distinction must be drawn. The operation is designed to correct certain uterine malpositions, and those alone. Whether the discomforts of the patients will be thereby relieved entirely depends on their dependence

on the uterine displacement. We will therefore divide the results into two heads:

1. How far is the operation of shortening the round ligaments of permanent utility in correcting uterine displacements.

2. How far is it beneficial in relieving the patients from the symptoms that have been supposed to depend on the displacements.

As regards my own practice, I can honestly say that I have never yet met with a relapse of any backward displacement after this had been placed in position by the operation.

In one case recorded in my book, my first case of old-standing retroflexion, and in which I did not recognise the necessity of the galvanic stem, the flexion exists, although the version is cured. In all the other cases of retroversion and retroflexion that I have performed during the last three years and a half—viz. 26 in number—I have never yet met with a relapse. I can therefore say that, as far as my experience goes, it is an absolutely certain remedy for retroversion and retroflexion, and as permanent as three and a half years' experience can guarantee me in stating.

In prolapse the mechanical results have also been nearly, although not quite so favourable. I have operated on 16 cases, and, strange to say, my penultimate case has failed completely, whilst all the others have been successes. When she wrote me, stating that such had been the case, I wrote back that she must be mistaken, and that I would not believe her unless I actually saw and felt the prolapse. She had been operated on in the hospital, was a short podgy woman, a sailor's wife. On receipt of my note she came to see me, and sure enough the uterus had come down. She had an extremely roomy pelvis, and, although she had a pessary in at the time, it also was shot out, and the os now rested inside the vulva, and was as 'sensible to feeling as to sight.' Some of my hospital prolapse cases I have never seen after they left hospital, but the majority I have examined again and again.

My 11th case, Mrs. W., upon whom I operated on May 2,

1883, is at present in hospital for hemorrhoids. The uterus is in excellent position. Previous to operation her uterus had given her distress for 4½ years. Since operation she has no pelvic troubles, except the piles that have lately troubled her. I removed these a few weeks ago.

It would be tedious to relate in full the particulars of cases to show that mechanically the operation is of permanent effect, especially as I have no percentage of failures to record. Of course some of my cases may have failed without my knowledge of that fact, but I can only say what I know. The second part of the inquiry relates to the benefit the patients have received as regards the relief of the symptoms that caused them to seek for medical advice.

The operation was originally devised to get rid of the swarm of patients with uterine displacements that infested the gynæcological wards at Liverpool Workhouse. Had the operation failed to relieve the symptoms, these would have been there still and vainly seeking relief as heretofore. Not one has ever returned with any uterine complaint (although many have been seen again and again since operation), except one, who thought her uterus was coming down. The nurse tested her every way, and I repeatedly examined her after running upstairs, and the uterus was never found to have descended from its post-operation position. On assuring her that it was all right, she went out quite happy. She had not complained of any symptoms, but was very afraid it was coming down, owing to a cystocele that protruded somewhat after extra exertion. From the nomadic habits of many of the hospital cases, it is impossible to find and verify each. In private practice the cases can more easily be found; and the following is the result of my older cases:

Mrs. C., my first private case (retroversion and pelvic neuralgia), in whom the uterus was antroverted slightly after operation, has lost the pelvic neuralgia from which she suffered, but it occurs in the head still. She is extremely neurotic, and it is difficult to ascertain her exact state. She

has not seen a doctor for nearly two years, which, I think, says a good déal.

Mrs. L., operated on in April 1882, for pains in the back, dyspeptic symptoms, and scanty menstruation, has enjoyed perfect health ever since.

In Mrs. C.'s case the flexion still remains, the version is cured, and so are all the pelvic symptoms. Attacks of *petit mal* still exist. This was my first bad flexion, and was spoiled, as I have already mentioned.

Miss C.—retroversion, enlarged bladder and cystitis—is much relieved; but she still wears a small Hodge's pessary, which I cannot persuade her to give up. Operated on November 28, 1883.

Mrs. W.—retroverted and prolapsed uterus. A delicate woman. No benefit. Afterwards diseased ovaries were diagnosed.

Mrs. S.—prolapse and dragging pains, and bedridden. Is now much relieved; she was attending to her children the last time I saw her, although she then had an idea she was to die from diabetes. Friends say she is much improved. Operation fifteen months ago.

Mrs. K.—retroflexion and prolapsed kidney, pelvic pains, and dragging. Uterus in position, and pains quite gone. Operation about eight months ago.

Mrs. Y.—retroflexion and prolapse—pelvic pains, great distress, and almost bed-ridden for a year previous to operation. Still complains of constipation and hepatic disease. Her husband says she is greatly improved. She says she is much better, and only feels tired when she works too hard. Her doctor says she is quite well. Operation ten months ago.

Mrs. R.—prolapse and subversion, dragging pains preventing her walking to any distance. Says she has felt quite perfect since. Operation in October last.

My more recent cases are still *sub judice*, but I may say that they promise as well as those just described. My cases I think show that I have not used the operation indiscriminately. Some surgeons have depreciated the operation because it is

not so certain as removal of the uterine appendages. It should never be entertained as a remedy for diseased appendages, and its use for such a purpose only tends to bring it discredit. It might as well be used for an ovarian tumour or cancer of the rectum. It should only be used for the cure of symptoms that depend on uterine displacements; and that there are symptoms depending upon these my operations seem to conclusively prove.

Of the dependence of symptoms upon uterine displacements. This question is too difficult and too wide a subject to allow of my entering upon it at the end of what is already a very long paper. While prolapse and version are treated by pessaries there will always exist strong reasons for the operation of shortening the round ligaments. The operation was previously designed for those cases where pessaries were specially inefficient or troublesome to manage, from whatever cause; but it may be performed in any case of prolapse and backward displacement in which the surgeon and patient may wish it to be performed, except those incurable miserable cases where bed and bandages are the only available remedies. By a more timely adoption of the operation such extreme cases would never occur.

To secure success the operation must be properly performed, and the after treatment must be rational, so that no strain be placed on the ligaments until sound union has taken place. I trust that what I have said will remove the discouragements promulgated by several as to the difficulty of finding the ligaments or the uncertainty as to their presence, and will assist the inexperienced to a successful performance of the operation.

Dr. MEADOWS: I shall be glad to hear the experience of any Fellows now. I am sure we are all very much indebted to Dr. Alexander for having come up from Liverpool, and we shall all consider his paper of extreme interest and importance. Perhaps when he replies he will kindly tell us what is the reason for using the galvanic stem. My experience in the use of galvanic stems is very unsatisfactory. I have seen

cases in which I have used galvanic stems which were followed with such unsatisfactory results that I use them no longer. Whether they are more harmless after this operation than in any other case I do not know. I should like to know the special use of this stem, and if any ordinary stem could not be used instead.

Dr. PROTHEROE SMITH: I should like to mention one case of Dr. Alexander's operation which I hope will turn out successfully. The patient had been under my care for some years for acute retroflexion, with a considerable sulcus at the point of flexion; and the uterus was very low in the pelvis, and the cervix uteri was so flaccid and feeble, that it had no power to sustain the enlarged body of the fundus. I tried various means in the way of pessaries &c., and to a certain extent they were successful; but invariably after a time it was necessary to remove them, so I determined, if another operation which I was about to perform should not succeed, that I would resort, before operating on a ruptured perineum which she had, to this operation of Dr. Alexander's. The first operation answered very well. It was found that there was considerable induration, which I dissected out, and, notwithstanding that an artery was wounded, and gave some little trouble, the case did remarkably well. She was exceedingly anxious that this ruptured perineum should be operated on, and I was very anxious to know if she would submit to this operation, which was a new one, and she at last said she would do so, as the use of pessaries and stems seemed to have no effect. I should say that her uterus measured 3¾ inches in length. Thinking that Dr. Alexander was probably a better operator than myself, I asked him to undertake that for me, which he kindly did, with success, so far as appeared at first. The uterus was held up as high as possible, and after the operation she had a galvanic stem introduced, with one of my elastic pessaries, which completely sustained the uterus *in situ*. The operation was performed with great ease, and I do not think that I should hesitate to perform another. The round ligaments were drawn out as far as they could be pulled and

amputated, and the uterus was drawn up considerably in consequence. The wound healed up readily, and she did very well. I kept her in the horizontal position entirely. On my return (I was unfortunately ill soon afterwards, and I was obliged to leave town, Dr. Heywood Smith looking after her in the meantime) I withdrew the stem and likewise the pessary, and found her uterus was so high up that I could not touch it with any pressure, and so I thought that after a few weeks she might get about a little to test it, which she did; but unfortunately she lay in a reclining posture, and I do not know whether Dr. Alexander has noticed before that this is calculated to go against the operation, from the pressure of the superincumbent weight of the intestines upon the uterus tending to depress it, and I think it was the case in this instance. I found that the uterus came down within the reach of the finger and was retroverted. At the same time, in consequence of the previous operation, the uterus had considerably lost bulk, and, instead of measuring 3¾ inches, it measured 3¼ inches. She always felt at the end of the day an aching in the groins and back, and as soon as she lay down and was perfectly quiet, the uterus resumed its normal position high up in the pelvis. After this I operated on the perineum, adopting Mr. Lawson Tait's improved method of operation, which I think very much more simple than the old method; and having got over that she has gone out of town. Although the uterus was so high up, yet I thought it quite necessary to put in an ordinary vulcanite stem, and likewise a Hodge's pessary, which completely holds the uterus in position and prevents strain upon the shortened ligaments.

Mr. LAWSON TAIT said: The operation Dr. Alexander has been telling us of is one I am not much in love with. I have done it only once, and that case nearly died. I was also deterred from the continuance of it by the occurrence of a fatal case—that is, a patient operated on by another surgeon died from the effects of the operation twelve months after it had been done under my care. We are not entitled to submit women to serious risk for the cure of retroversion or

retroflexion. Last August twelvemonth I had the pleasure of discussing the question with Dr. Alexander, and he showed me one or two cases which were wonderful. I did not have the chance of seeing the operation done, having missed a demonstration which he had for my benefit, if I remember rightly, at his hospital. I was so impressed by what I saw, and the cases he showed me, that I determined to do the operation; but a most unexpected block came in the way—the patients would not submit to it. I proposed it to a large number of cases of retroflexion and retroversion, but I was eighteen or twenty months before I could persuade a single case to submit to the operation. It is my practice to explain what I am going to do to my patients, and I do not usually have much difficulty in persuading them to have abdominal section when I think it required; but I tell you I have only done one of Alexander's operations—only succeeded in persuading one woman to submit to it; but there the fact remains. I sent the chief of my staff, Mr. John W. Taylor, to see the operation done by Dr. Alexander before I did this one. He came back with a very intelligent description of Dr. Alexander's proceedings, and in the case I speak of I did not find any difficulty. The operation was done with the greatest ease, and therefore I will say that the shortening of the round ligaments is an extremely efficient remedy for retroversion. I got the uterus perfectly in its place, and there it remains, but my patient was nine weeks getting well. The wound suppurated, the temperature went up 40°, the pulse was 140, and she very nearly died; she was in the same hospital with fifteen or twenty cases of abdominal section, with none of whom I had any trouble. That is my personal experience of the operation, and I do not feel very enthusiastic about it.

The fatal case I have spoken of occurred very soon afterwards. There a well-known surgeon had performed the operation thirteen months before the patient came under my care. After the operation she had been troubled in a mysterious way with the bladder. She had some very

troublesome symptoms, which I regarded as septic, and the only thing I could discover to explain the bladder symptoms was a curious hard mass on the left side of the uterus. This remained perfectly hard and solid, and I thought it was one of the remains of Alexander's operations which had been performed, and it turned out I was quite right. I did not believe it had anything to do with the bladder symptoms, and therefore I opened her bladder in order to establish fistula. I kept it open for about a week, and then it healed, and the patient was all right; but she lay nearly a month in the hospital with an enormously high temperature and high pulse, and finally she died. At the post-mortem it was found that the whole trouble was due to suppuration under the track of the round ligament, which had been so shortened —so this should really be reckoned as a fatal case of the Alexander operation. Under these circumstances I do not suppose there is much blame to be attached to the operation; probably the blame is the operator's, because other people tell me—Dr. McClintock, Dr. Cleason, and other surgeons who have done this operation tell me that it gets well without any trouble; but in my own case the trouble was so great that it was a damper to my enthusiasm, and the fatal case has certainly not conduced to any alteration of my views.

Dr. HEYWOOD SMITH said: I did the following operation some years ago, in a case of retroflexion that had resisted all known methods of treatment. I opened the abdomen, and, pulling up the uterus, attached it to the abdominal wall by a silk ligature. The patient was, unfortunately, one of those women who are never quite satisfied; and she declared she felt the uterus drop whenever she stood up. I examined her standing, but the uterus was in its proper position. The uterus was large enough to reach the abdominal wall without much tension.

Dr. ALEXANDER, in reply, said he only used the galvanic stem for mechanical purposes. Any other stem of the same size will do, but few other stems are of the same size, and hold the uterus so steadily. After the round ligament operation,

the uterus being pulled forwards out of the line of pressure, none of the troublesome results referred to by the President as arising from the ordinary use of the galvanic stem has adhered to his cases. Dr. Protheroe Smith's case will finally be successful, provided he takes care to keep the uterus straight by a stem until the fundus has lost the power of recoil.[1] Retroflexion cases are perfectly amenable to this operation, provided the stem is maintained long enough in position. If that is taken out too soon the fundus recoils and the disease returns.

In reply to Mr. Reeves, he never recommends inch incisions. He always makes the incision an inch and a half or two inches long, and would recommend beginners to take plenty of room. The only way to detect adhesion of the uterus was by the sound. If the uterus cannot be replaced by that instrument, it is not likely to be capable of replacement by the operation. In one of his cases where there were some adhesions the operation succeeded, as during the healing of the wound the adhesions yielded; but such a result could not be expected often. In regard to pregnancy the round ligament operation does not seem to interfere with its course or termination. One case became pregnant, and was delivered of a child at full time without any trouble and without any recurrence of the backward displacement. Mr. Lawson Tait saw the case several months after confinement and verified the excellent position of the uterus. Dr. Imlach mentions two cases of his where pregnancy occurred and where the children were born without any trouble. In one of these some cellulitis occurred, but there is no proof that it was due to the shortening of the round ligaments.

In reply to Mr. Tait, he said his patients were not only willing, but mostly eager for the operation to escape from what to many seems an unbearable nuisance, the wearing of pessaries. Of course accidents may occur and suppuration and death even may result; but at the present time, and with

[1] Dr. Alexander saw this case since with Dr. Smith, and the uterus was then quite straight and in good position. Dr. Smith's pessary was still *in situ*, but no stem pessary.

the recent great advances in surgery, these things ought not to occur, and are entirely the fault of the surgeon. In an ordinary case a little pain for a few days, and retention of urine for twenty-four hours, are the only real troubles, both of which can be easily remedied.

The operation seems the safest performed at the present time.

The Society then adjourned.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, JUNE 24th, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 47 Fellows, 1 Visitor. The following gentlemen were elected Fellows of the Society:—Dr. R. C. M. Pooley, Dr. E. S. Stevenson, Dr. J. H. Allden, Dr. J. W. D. Hooper, Dr. F. W. Strange, Dr. H. L. Smith, Dr. G. H. Darwin, Dr. J. J. Macan, Mr. J. B. Sutton, Dr. J. T. O'Donnell.

The following gentlemen were proposed for election:—Dr. Alexander Dempsey, Belfast; Dr. Mark Antony MacDonnell, London; Dr. Samuel Kennedy, London.

Dr. Fordyce Barker, of New York, was elected an Honorary Fellow of the Society.

Mr. LAWSON TAIT showed the following specimens:—

1. A small dermoid cyst which was found by accident in an ovary removed for myoma. It consisted of a small follicle about half an inch across, in which were coiled up a quantity of short hairs, most of which had been shed, and the rest of the contents of the cavity being the fat found in such cavities. So far as Mr. Tait knows, it is the smallest dermoid tumour which has yet been exhibited.

2. A stone removed from the kidney of a patient aged fifty-nine, who had suffered for some years from symptoms of stone in the kidney. The patient had made an easy and rapid recovery.

3. The preparations from a case of pyosalpinx in which the disease appeared in an acute form under some endometric treatment. As the case was an extremely important one, Mr. Tait proposes to publish it in minute detail.

4. The preparations from a case of double pyosalpinx, in which the tube was so distended as to contain between three and four pints of pus. The patient was very young, and the diagnosis had been made by Mr. Tait of a uterine myoma with a cystic tumour of the left ovary. What was supposed to be a myoma was the right fallopian tube enormously distended and densely attached to the pelvis. On vaginal examination it felt perfectly solid. What was supposed to be the cystic tumour was the left fallopian tube equally distended and pressed down towards the brim of the pelvis, so that fluctuation could be easily detected in it. This was one of the cases of chronic pyosalpinx without any marked symptoms, forming an altogether different class of case from most of the other examples which Mr. Tait had previously exhibited. It was indeed far more like what is called a cold abscess than anything else, there being really hardly any pain. The operation was extremely difficult, and the hæmorrhage from the adhesions very troublesome.

5. The preparations from a third case of a distended and occluded tube, with a cyst at the end of the tube of a nature which was perfectly unfamiliar to Mr. Tait, the ovary being in this case perfectly healthy; but curiously enough the operation was performed for symptoms of acute pelvic peritonitis. The tube and cyst were found rotated, so that the fallopian tube resembled very closely the appearance of an umbilical cord, and the cyst was in a semi-gangrenous condition, adherent by recent lymph to the posterior surface of the ovary, where it was felt easily before the operation. The contents of the cavity of the fallopian tube were purulent, so that the previous diagnosis of pyosalpinx was correct.

Mr. LAWSON TAIT also exhibited the appendages from a case of double pyosalpinx, removed a few days previously from an unmarried lady aged thirty-seven.

The disease seemed to begin in a long strain induced by nursing. She had been treated for displacement in various ways, suffered intense pain before and during her menstrual periods—menstruated too often, for five or six days each

time, very profusely. She suffered from profuse intercurrent leucorrhœal discharge. Eighteen months previously she had been treated for seven weeks by Dr. Playfair according to Weir-Mitchell's process of massage. Upon this treatment she improved, and her pain was relieved; but very soon after its cessation she was as bad as ever. The uterus was found retroverted and adherent, two small tender masses being found one on each side of the uterus. Mr. Tait made the diagnosis of occlusion and distension of the tubes, and upon operation the contents of both were found to be purulent. The patient has made a good recovery.

Dr. BANTOCK said that the case which had been particularly commented on illustrated in a very striking manner the great importance of making as accurate a diagnosis as possible, and how very valuable methods of treatment were liable to be brought into discredit by misapplication through error of diagnosis, or perhaps through omitting the attempt to make one. He illustrated his argument by a reference to cases which had come under his own observation. In the first case a lady had been an invalid for nine years, and the opinion had been expressed by an eminent gynæcologist that the case was most unfavourable for the Weir-Mitchell method, for he would first have to reduce the patient and then build her up. Such an opinion could only tend to bring discredit on a method which, rightly applied, yielded most satisfactory results. In this case an imperfect diagnosis was made, and although it was one in which an accurate diagnosis was exceedingly difficult, if not impossible, yet there was sufficient to indicate local disease as the cause of the symptoms. Both ovaries were cirrhotic and cystic, and it was evident that this disease was the cause of the symptoms, for the removal of these with the tubes resulted in a perfect cure. To illustrate the difficulties of diagnosis, he quoted another case in which no less a master of his art than was the late Dr. Marion Sims diagnosed an enlarged ovary where the ovary was actually atrophied to such an extent that it took a very long time to find it. Even with the aid of an anæsthetic an accurate diagnosis was often

impossible ; and here it was that we were so much indebted to the boldness and skill of Mr. Lawson Tait, who had taught us to open the abdomen in such cases as, from the symptoms, have indicated local disease.

Dr. EDIS directed attention to the extreme importance of forming a correct diagnosis in those distressing cases of neurasthenia, before submitting them to treatment by means of seclusion, massage, galvanism and dieting. In one of the cases mentioned by Mr. Lawson Tait an error in diagnosis had doubtless not only led to a course of improper treatment, but had also contributed to the danger of a rupture of the pyosalpinx taking place.

Dr. HEYWOOD SMITH exhibited two fibrous tumours of the uterus which he had removed from two patients. The first was the case of an unmarried woman aged over sixty, who had been suffering from hæmorrhage for several years, and was greatly blanched by the loss. The os uteri was dilated with Hegar's dilators, and a tumour was found presenting at the inner os. This was seized with a vulsella, and drawn down, and the wire of an écraseur passed over it, and a large portion cut away. A further portion was felt, but as the uterus was contracting it was left for a time. Two days afterwards, the temperature having risen a little, and the tumour being still further pushed down by uterine action, the écraseur was again applied, when it slipped over the end of the tumour at its attachment to the fundus, which was easily cut through, as the wire was over the rounded end of the tumour, so that it was quite shelled out. The patient recovered well.

In the second case the patient, a married woman, suffered from severe pain in the right inguinal region, and a fibrous tumour of the uterus was diagnosed on the right as part of the body. The cervix uteri was dilated with Hegar's dilators, and above the inner os a slight elevation was discovered on the right wall of the uterus, but beyond this no indication of the tumour, save by a bimanual examination. An incision was made freely over this elevation, and with great difficulty

the fibrous tumour was enucleated from its bed and removed partly by torsion and partly by avulsion. The cervix uteri was somewhat damaged on its right aspect. The patient was in considerable danger for a few days from some septic absorption from the torn parts, but she recovered well.

Dr. HEYWOOD SMITH considered that the operation of enucleation of fibroids was at all times a hazardous operation, but cases occasionally arose where the position of the tumours, and the pain engendered by their size and position, necessitated the attempt to remove them *per vias naturales*. He was of opinion that enucleation should be completed at one operation, as the leaving of a fibroid in the uterus partly enucleated exposed the patient to severe risk from septicæmia.

Mr. TAIT, in speaking of Dr. Heywood Smith's cases of enucleation of myomata, said that Dr. Smith himself had admitted, what was patently a fact, that such operations were extremely dangerous; so dangerous were they in Mr. Tait's estimation that he regarded them as absolutely unjustifiable. If the statistics of a hundred such cases could be obtained, it would probably be found with the mortality of 90 per cent.; and even if the patients recovered, there was no guarantee that the disease would be cured, for such tumours were constantly associated as small nodules, which on the removal of their predecessors started into active life. Mr. Tait had already published cases in which the disease had recurred after enucleation, requiring the subsequent removal of the uterine appendages. As this latter operation had now reached such complete success as to be fatal in probably not more than 3 per cent. of cases, in his opinion it ought to be substituted for enucleation, and where possible for hysterectomy.

Dr. PROTHEROE SMITH said that, whilst he agreed with Mr. Lawson Tait that it was inexpedient as a rule to operate on intramural fibroids by enucleation through the natural passage, there were nevertheless to be found exceptional cases in which it could be undertaken with success. In proof of this operation, he mentioned the case of a lady who had a very large tumour of this character which reached to near the umbilicus, which he had prepared by gradually dilating the

vagina, and afterwards the cervix uteri, so as to admit the hand. Finding the tumour very large, he incised its capsule longitudinally, but in detaching it he thought better to remove, with it, the lining membrane which formed its uterine envelope. This required long time and great care, the peritoneal surface of the tumour being thin. When the whole was separated, the fibroid resisting all efforts to withdraw it from the pelvis, this was accomplished by dividing it by the écraseur, when it was seen to be about the size of the head of a full-grown fœtus. The packing of iodised wool was removed next day, and she made a rapid recovery. After two years he found the uterus normal in size and position, and the patient free from ailment. This case having been so successful, he thought it well to suggest in enucleation of fibroid the removal also of its uterine envelope.

ADJOURNED DISCUSSION ON DR. MORE MADDEN'S PAPER.

Dr. BARNES submitted that it was impossible to lay down any universal rule in dealing with fibroid tumours of the uterus. They varied infinitely in their conditions, so that thus, in the presence of a case, he was compelled to study its peculiar features, and to treat it on its individual indications. In discussing the subject, it was in the first place desirable to classify these tumours. There was the generally recognised distinctions as to locality—namely, the sub-peritoneal, the mural, and the submucous, the first tending to protrusion from the outer surface of the uterine wall.

These were of the least clinical importance. Being planted more out of the focus of activity of the uterus, they did not often cause hæmorrhage; they often were quite inert. He had watched several cases of women having tumours of this kind, who went through successive labours without the smallest inconvenience from them. Such cases did not call for operation, unless the tumours happened to fall into the pelvis, and so cause distress by pressure. Then there was the intra-mural tumours. These, seated within the focus of

uterine activity, were commonly attended by severe symptoms, as pain, hæmorrhage, and pressure upon contiguous organs. Dangerous conditions might be developed long before they showed a movement of extrusion either towards the outer or the inner surface of the uterine wall. It was a gross error to believe that these tumours did not call for energetic treatment. To trust to the process of atrophy under the climacteric process would in many cases be to trust to what might never occur. Either the patient might be destroyed before the climacteric arrived, or the tumours would go on growing notwithstanding the climacteric. Hæmorrhage alone might kill; but a greater danger was from pressure, first upon the bowel, obstructing the function of nutrition, and thus slowly breaking down health and the power of resistance to intercurrent trials: and secondly, and more surely, to pressure on the bladder, leading to cystitis; obstruction to micturition, and ascending disorder of the urinary apparatus (as distension of the ureters), then of the pelvis, of the kidney, and organic disease of the kidney. Thus he had seen cases end by urinæmia. When once it was clearly seen that pressure was telling upon the bladder, it was of urgent importance to act promptly. In some cases of mural tumour the new growth was diffused in the uterine wall, and did not form a distinct mass encapsuled and capable of enucleation. In these cases, removal of the ovaries, or even entire removal of the uterus, might be necessary.

He could not help thinking that Mr. Lawson Tait's dictum in favour of removing the uterine appendages as soon as a fibroid was detected—if he rightly understood him—was too absolute. He could not in the early stages predicate what course the tumour would develop. It might remain small and passive, producing no symptoms to justify serious operations; it might undergo spontaneous atrophy or calcareous degeneration; it might be protruded in a polypoid form into the uterine cavity; it might undergo necrosis and be cast out. Pregnancy was sometimes a cure. In St. Thomas's Hospital Reports Dr. Leonard Sedgwick had re-

ported cases in which tumours had disappeared after pregnancy. He himself had seen some remarkable examples. It might happen in two ways—first, by the tumour undergoing necrosis and being enucleated under the process of labour and puerpery, as in a case he had presented to the Obstetrical Society; secondly, by simple absorption or involution, just as the superfluous uterine tissue did. He referred to this termination as an illustration of the natural history of these growths, showing one mode of cure, and not by any means as an encouragement for women with fibroid tumours to marry. The dangers were too great, and the prospect of cure by pregnancy too small to justify trying this method.

Fibroid tumours must further be differentiated according to their seat: whether in the fundus, in the middle zone, or in the lower zone and cervix. Those growing in the fundus are less dangerous than those growing in the lower zone and cervix. These last are apt to distort the uterine canal, leading to dysmenorrhœa, if not to hæmorrhage also, and are especially apt to cause dangerous pressure upon the pelvic organs. These cases especially called for treatment. Pain amounting to agony, disabling the patient from exertion, compelling her to seek refuge in bed, was not uncommon.

Now, in studying treatment before concluding that removal of the uterine appendages was necessary, it would be useful to begin with considering those cases of fibroids which have gone so far in the natural process of extrusion as to assume a distinct polypoid condition. When the tumours had taken this course, or were tending to it, removal by the écraseur wire was obviously the proper and simple method to adopt. Then, rising from these cases of pedunculated tumours to others in process of extrusion, we met with tumours in every stage of the process, gradually coming to tumours with a broad basis, a large portion of which was still imbedded in the uterine wall. Many of these might be successfully dealt with by a combination of dragging, spiral elongation, the écraseur, and enucleation. It was, however, necessary to determine carefully whether the size of the tumour admitted

of its being delivered through the natural passages. If too large for this, the operation was eminently dangerous and should not be attempted. It was not, however, always necessary to remove the entire tumour at one sitting. If a large portion were removed at one sitting, the remaining portion might undergo necrosis or atrophy, resulting in cure, or it might be further extended by a process of spontaneous enucleation, so as to admit of complete removal at a second operation. This he had on several occasions practised with complete success; in one case quite recently. Then we come to a third class of cases in which there is no distinct tendency to extrusion into the uterine cavity; no possibility of removing them by enucleation with reasonable prospect of safety. In such cases we may sometimes succeed by piercing the tumour with the galvanic cautery, with the object of setting up a process of necrosis or atrophy. If the symptoms are urgent, the resource of removing the uterine appendages, or the more desperate one of removing the uterus, must be considered. Dr. Barnes would not dwell upon treatment by medicines or by electricity. Occasionally useful, those agents were too tedious and uncertain. They must mostly be regarded as expedients for gaining time, with the risk of losing time. In several cases he had seen complete success from a proceeding adopted by Baker Brown—that of incising the cervix uteri. This was especially useful in cases where the tumours invaded the cervix and lower zone. He had found tumours to disappear completely in this way. He had also practised oöphorectomy with the most satisfactory results.

Dr. ROUTH said Dr. Barnes had, in his eloquent address, forestalled him in many points he had raised, which had he (Dr. Routh) been fortunate enough to speak first, he might have mentioned. It appeared to him, however, that in some of the addresses, and even Dr. More Madden's able paper, the discussion had been too much confined to three modes of treatment: enucleation, removal of the appendages, and extirpation of the uterus itself by the abdominal section; whereas there were at least five or six other modes of treatment which

could be adopted, some of which had been referred to by Dr. Barnes.

First, he would speak of enucleation. Besides the cases mentioned by Dr. More Madden, Dr. Heywood Smith's two cases instanced that night, and which he had so ably handled, proved the tremendous hazard of many such operations. In one of Dr. Smith's cases, which was concluded by twisting, it was recorded that the parietes of the uterine cavity were exceedingly thin. What more likely to occur in other cases than the tearing of this thin coating, and if this occurred, he (Dr. Routh) would fear recovery would be very doubtful.

Secondly, he believed there was a preferable way of dealing with these and similar cases—namely, *division* pure and simple with the knife, where the tumour was not of very large dimensions; not only by cutting open the os on either side, as instanced by Dr. Barnes, but by previous dilatation, and then cutting right through the capsule deeply in the tumour. He had seen ten cases so treated by Mr. Baker Brown, and in which absorption was at once induced and a cure effected. Such incisions seemed in some way to arrest the nutrition of the tumour, which then gradually, sometimes very quickly, disappeared. In one case which he had very lately treated in a lady in whom he had removed two partially parietal and intra-uterine tumours, of the size of small oranges, which he twisted off piecemeal at several sittings, he found higher up another tumour, as large as an orange, projecting. This he freely incised, and the lady had had no return of her menorrhagic troubles, the tumour disappearing. The rapidity with which some of these tumours disappear at, or even before, the menopause in some cases was truly marvellous. He remembered attending two ladies—and, curiously enough, at the same time—in both of which there were two tumours lying side by side, in each about the size of a child's head. Under appropriate treatment these ladies both lost their tumours. One died later in life from heart disease and pneumonia, the other was now living and quite well. Of the rapidity with which some of these tumours

disappear he had once a very painful yet most interesting example. He could not publish it because the records were stolen by a dishonest official, but he could relate its chief features from vivid recollection. This woman was sent to him by Dr. Godwin Tims labouring under a very large fibroid apparently attached to the greater part of the left lateral wall of the uterus, and projecting as a polypoid growth out of the cervix, the size and shape being that of a large cocoa-nut, but twice the length. That part projecting into the vagina appeared to be necrosing. This portion he removed with the écraseur. Imagine his horror in seeing the next day, projecting out of the vagina, some two or three inches in length, a quantity of membrane. His first idea was it was the bladder which he had unintentionally cut, and the ends of which were projecting outside the vulva. But examination showed it was continuous with and forming part of the intra-uterine growth. This portion was again removed. He was then obliged to leave her under Dr. Greenhalgh's care, being telegraphed for to Manchester. The same trabecular membrane of the fibroid again came down, projecting out of the vulva. This he removed as he had done. The next day the same thing recurred, but before this could be removed she died from exhaustion and septicæmia. The post-mortem was most interesting. The uterine cavity was filled with the trabecular membrane, which had enclosed the fibroid up to about an inch of the uterine wall of the left side, where what remained of the tumour was sessile over a large extent. This cut through was found very white and enclosed in meshes of membrane similar to that which had projected out of the vulva. This part of the tumour was quite fresh ; that in contact with the liberated membrane gangrenous. Thus in some four days a very large fibroid, partially parietal and partially intra-uterine, was all but absorbed away. Had he known as much of antiseptic surgery as he did now, he thought he should have saved this woman's life.

'This brings me, thirdly, to gouging. Mr. Baker Brown was, I believe, the originator of this plan. He gouged away by a special instrument those tumours, removing a circular

elongated piece. This he filled in with lint till inflammation of the tumour at this part recurred, possibly gangrene, absorption was set up, and the tumour disappeared. But although Mr. Brown had related several cases of success, he erred here, I think, in three ways. At first he used to cut the os open and then at once proceed to gouge. Later he saw his error and waited till the cut os had healed, and so septicæmia poisoning did not occur so rapidly. 2nd, he cut *too deep*; a much less deep gouging would suffice. And, 3rd, he did not practise accurately enough antiseptic measures. I believe, if he had corrected the two last errors, he would have succeeded much better. The gouging is only another way, possibly a more *risky* way, of setting up absorption in a tumour.

'Fourthly, Dr. Barnes has spoken still doubtingly as to electrolysis. I believe in cases of parietal fibroids it is often successful. But it must be practised forcibly. I have seen tumours disappear after this treatment. One case especially I recall in a woman who had a large fibroid, through which I passed a current which was used as cautery, guarding the poles with wet lint. It was a largish-sized tumour. A good deal of inflammatory pain in the tumour followed, but that disappeared rapidly. In another I had the same success, although in this case a small hole was burnt in her back. I saw her also years after; she was quite well. The absorption may be set up likewise, following Dr. Greenhalgh's plan, although in a somewhat modified manner, by piercing the tumour first with a long needle and then applying a strong electrical current through it. Also by careful and minute injections of bromine or iodine.

'Fifthly, Mr. Lawson Tait, Dr. Bantock, and others have told us menorrhagia often kills these cases; hence it is expedient to arrest this often at any cost. But why have they not alluded to uterine injections of iron or iodine in these cases as in those of post-partum hæmorrhages? Now this is a perfectly simple measure, and if, as Dr. Savage and I have shown,[1] the uterus be previously dilated, as it is

[1] *Obstet. Trans.* ii. 17.

after delivery normally, by sea tangle, so as to allow of the free exit of the astringent used, you can arrest this hæmorrhage and save your woman. Only the other day I was called to such a case and injected about ʒj of perchloride of iron tincture, and immediately arrested it. I usually prefer performing it with a vulcanite pipe drilled with small holes, so that the iron is forced out almost like spray; iodine paint may be also used in the same manner. Sometimes a long bougie partially covered with cotton and dipped in either solution may be introduced through a speculum, and be equally effective.

'Sixthly, Dr. Barnes has told us pregnancy will sometimes lead to absorption of the tumour, synchronously with the absorption of the hypertrophied uterus which normally occurs after pregnancy. Only lately, in the case of a lady who had been married seven years without a pregnancy (and in whom I introduced one of my buckle pessaries, to keep the os open, and who became soon pregnant after its removal), labour was greatly impeded by a large fibroid, previously undetected, in the posterior wall of the uterus, of the size of my two hands placed one over the other. This tumour no doubt had increased with the pregnancy. It materially impeded the labour, but I succeeded in delivering by forceps, and a large healthy child was born to cheer the parents. All went on well, and when I saw her several months after I could not trace the tumour.

'And this leads me, seventhly, to consider by way of contrast the removal of the appendages in cases of excessive menorrhagia. Here we really want facts. Is it always successful? Certainly not; moreover, it is certainly more hazardous in London than in Edinburgh or Birmingham. We should remember that in London our air is not pure. Our hospitals are not on high hills, or in country localities. We have fogs and mists and very dirty weather, especially in winter. Now nobody is a greater admirer than I am of Mr. Tait's pluck and successful abdominal sections. I in no way doubt his skill, nay, I acknowledge it fully and entirely, but

surely pure air has something to do with his and Dr. Keith's marvellous successes. But are we right in *unsexing* a woman except as a *pis aller*? Pregnancies are not precluded by the mere presence of a fibroid; they are sometimes curative of them, and happy mothers are often made in spite of their fibroids. Not so if deprived of their appendages. What is a woman without these? Her mental qualities, thank God, may remain intact, but the body is useless for one of the greatest objects of her creation.

'I cannot at this period of the evening enter upon the subject of hysteridectomy. But I think, with all diffidence, it should be also a *pis aller*. Only in those cases where it is too large to be treated *per vias naturales*, or where it is high up in the pelvis, should the operation be performed. As regards extra-uterine fibroids, they are not so get-at-able. They do not produce much discomfort except when very large, but statistics prove that these are much more safe to remove. I have shown this in my Lettsonian Lectures on Fibroid Tumours of the Womb, and since their publication enlarged experience has only confirmed this conclusion. Moreover, fibroids within the walls of the uterus, and extra-uterine fibroids, have a totally different origin. The parietal fibroids are the result either of long-continued active congestion of the uterus or metritis. I have followed this progressive change. The uterine organ is much enlarged. It is treated and reduced. One part in it, however, still remains enlarged and hard; this is the developed fibroid, which then may proceed to enlargement or absorption. Extra-uterine fibroids are merely dropped ova, which become attached to the peritoneum covering the uterus, and from proximity to the uterus develop, and on their enlargement acquire tissue closely resembling uterine tissue. These extra-uterine tumours, however, are little affected by internal remedies. Hence another reason for their extirpation.

'The parietal fibroids are, I am convinced, absorbed by Woodall Spa water, Kreusnach water, small doses of mercury, ergot, chlorides of ammonium or calcium, and bromide of

potassium. Even *pure sea water*, drunk as a mineral water, will produce absorption. Iodine externally over the abdomen, internally and applied to the uterine cavity, acts sometimes in a very marked degree, diminishing the size of these tumours.'

Dr. EDIS stated that he could disprove one statement of Dr. More Madden as to the fact that fibroid tumours 'never directly destroyed life.' Dr. Edis had witnessed such cases, not only from hæmorrhage but also from septicæmia, the result of sloughing of an intramural and partly sub-mucous fibroid.

The statement also that 'in the majority of cases uterine fibromata become arrested in their development and symptoms by the changes consequent on the menopause' was far from representing the true nature of these cases. The fact was, that the menopause was indefinitely postponed and the patient reduced to a condition of confirmed invalidism, unable to earn her living or to fulfil her domestic duties, a misery to herself and a burden to her friends. In place of advocating the expectant mode of treatment until the patient's health was so deteriorated that any operative measures would be attended by very grave risks, the more rational plan would be, having tried palliative treatment and failed to repress hæmorrhage or improve the patient's condition, to resort at once to one or other of the various operations—oöphorectomy, enucleation, or hysterectomy. In many instances mere division of the cervix was sufficient to check hæmorrhage, relieve dysmenorrhœa, and arrest the growth of the fibroid. Dr. Edis had tried this method most successfully in suitable cases. Enucleation could also be carried out with comparatively slight risk in many instances where nothing was attempted beyond medical treatment, which was practically of little or no use.

Dr. EDWARDS said—I should like to make a few remarks upon this discussion of enucleation of internal fibrous tumours of the uterus. In the first place, I beg to endorse Dr. Routh upon the ten cases he saw operated upon by the late Mr. J. Baker Brown, at the London Surgical Home. I was also

present at those operations, performed in 1859 and 1860. I believe Mr. Brown was the first London surgeon who performed the gouging operation. The patient, 'under chloroform,' was placed in the lithotomy position, and a Bozeman's speculum introduced. He then divided the os and cervix freely, brought well into sight the fibrous tumour, which he pierced in the centre and then cut out from it a portion much in the manner of coring an apple. Through the cavity thus formed he broke down as much as possible the surrounding tissue of the tumour, and then concluded the operation by placing oil and lint in the incisions and plugging the vagina. There was no return of hæmorrhage after the division of the os and cervix. I have had a great number of cases, and have operated upon thirty, with only one death. The patient was a single woman, æt. 27, suffering from uterine hæmorrhage for the last four years. On examination I found a large tumour in the anterior wall growing into the cavity. Dr. Meadows also examined her, and confirmed my opinion. I divided the os and cervix and made an incision through the capsule at the most depending point. I plugged the cavity with oakum and carbolic oil. After she recovered from the effects of chloroform, I gave ʒss. doses of fluid ext. ergoti to excite uterine contraction. There was no return of hæmorrhage after the operation. The patient died of pyæmia on the sixth day.

A Case of Ovariotomy. By VINCENT JACKSON, Esq., F.R.C.S.

W. A. B., æt. 29, the first patient received into the Women's Surgical Infirmary in connection with the Wolverhampton and Staffordshire General Hospital, was admitted March 1885. Married twelve years, has had six children, the eldest being 10 years of age and the youngest 10 weeks. History of menstruation and general health good. Seven months ago when pregnant considered herself larger than during previous pregnancies, but beyond this there was no other indication of the existence of a tumour until her confinement last December, shortly after which one was detected, and it was owing to its

rapid growth, and the great discomfort it occasioned, that she presented herself for admission. Upon examination there was no difficulty in forming the diagnosis of the presence of a left ovarian tumour with thin walls. The evidence of the existence of adhesions was almost *nil*. Girth at umbilical line was 42 inches. An operation was recommended, and the patient willingly assented, but the performance of the same was delayed until completion of the new department for such special operations.

On April 18th ether was administered, and ovariotomy was performed. A small quantity of fluid escaped immediately the peritoneum was incised. A thick membrane of lymph separated this membrane from the cyst wall. The introduction of the hand broke this down, and enabled the relations of the cyst to the abdominal walls and viscera to be determined. Very extensive adhesions were encountered anteriorly also on the left side, and one very tough attachment to the pelvis was left to be dealt with at a later stage. The larger viscera seemed free. A trocar was pushed into the tumour, but only a little thickish fluid flowed away; the cyst wall was so soft and thin that the slightest traction caused it to tear in more than one place, letting free a considerable quantity of gluey fluid. The right hand was thrust within the cyst, and as much of the interior as possible broken down and pressed out, and with one hand inside and the other outside the tumour was extracted. Now the broad adhesion to the left pelvic brim was ligatured and then divided. Attached to the tumour for a considerable distance was a long length of the great omentum as well as a piece of the small intestine; the latter was pulled off, and the former, after being ligatured in several places, was cut away. It measured fifteen inches by six. The pedicle was tied in two positions by strong silk, cut across and dropped into the pelvic well. The right ovary was healthy. After a complete cleansing of the peritoneal cavity, a glass drainage-tube was inserted, and the abdomen closed by means of nine deep silk sutures, and the dressings having been applied, the patient was placed in bed

and soon rallied. Her progress to convalescence was rapid. On the fifth day the drainage-tube was removed, having given exit to 17½ ounces of red serum, and on the twenty-first day she left for a convalescent home. The specimen, which weighed five pounds, was reported to be a well-marked example of a compound cystic ovarian tumour.

The Society then adjourned.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, OCTOBER 14th, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 31 Fellows, 5 Visitors. The following gentlemen were elected Fellows of the Society:—Dr. A. Dempsey, Dr. M. A. MacDonnell, Dr. S. Kennedy.

The following gentlemen were proposed for election:—Dr. John Butler Edis, Liverpool; Dr. William McGeagh, Liverpool; Dr. William Erskine, London; Dr. William Sidney Jebb Scott, London; Dr. Henry Trotter Rutherford, London; Dr. Charles Hanlen Gamble, Barnstaple; Dr. George J. Englemann, St. Louis, U.S.A.; Dr. William Heath Byford, Chicago, U.S.A.; Dr. William Henry Baker, Boston, U.S.A.; Dr. P. Flewellen Chambers, New York, U.S.A.; Dr. Paul F. Mundé, New York, U.S.A.; Dr. John Wellington Nosebrugh, Hamilton, Canada; Dr. Emilius Clark Dudley, Chicago, U.S.A.; Dr. Horatio Ripley Bigelow, Washington, U.S.A.; Dr. James P. Boyd, Albany, U.S.A.; Dr. William M. Polk, New York, U.S.A.; Dr. Albert Vanderbeer, Albany, U.S.A.; Dr. Robert Battey, Rome, U.S.A.; Dr. John Bradbridge Hunter, New York, U.S.A.; Dr. A. Reeves Jackson, Chicago, U.S.A.; Dr. Charles Jewett, Brooklyn, U.S.A.; Dr. Alexander J. C. Skene, Brooklyn, U.S.A.; Dr. Walker Gill Wylie, New York, U.S.A.; Dr. Charles James Wright, Leeds; Dr. James Hayward Hough, Cambridge; Dr. James Herbert Simpson, Rugby; Dr. Francis Imlach, Liverpool; Dr. Robert Alexander Jamieson, Shanghai.

The PRESIDENT, in welcoming the Fellows of the Society

back from their holidays to the work of a new session, stated that during the recess their indefatigable secretaries had been actively employed, and in ways which demonstrated the increasing popularity and success of the Society, in proof of which he mentioned that the first edition of the second number of their 'Journal of Gynæcology' had rapidly become exhausted; and the demand for it continuing a new edition had been printed, which was also being freely sold. Another fact might be mentioned, viz. that they had that evening no less than 28 nominations for the Fellowship of the Society, which now numbered upwards of 360 Fellows. The facts, he thought, spoke with practical eloquence as to the wisdom of those who founded the Society, while they testified to the want which this Society supplied. He congratulated the Fellows on their unprecedented success, which he ventured to predict would continue to increase.

Dr. FANCOURT BARNES showed a large syphilitic condyloma which he had removed from a young married lady. It measured 5½ inches in circumference and sprang from the left nympha. It was the size of a large pear.

Dr. EDIS showed a myoma the size of a cricket ball which had been expelled from the uterus, remaining attached by a small pedicle about the diameter of a shilling piece. It was subsequently extruded from the vagina during efforts at defecation, simulating inversion of the uterus, for which it was at first mistaken. It was removed by means of the écraseur.

The special point of interest consisted in the fact that the patient had been seen in the out-patient department of one of our largest metropolitan hospitals and referred to a special hospital, where she was admitted and remained for four months on the supposition that she was suffering from cancer of the uterus.

The particulars of the case were as follows:—

S. D., aged 44. Mother of 4 children. Widow. Youngest child 16 years old. Patient was in good health three years ago, since when she has suffered with pelvic pain and discomfort, the monthly periods being very profuse. Two years

ago she was subject to violent attacks of pain in the lower abdomen, with forcing sensations, two or three times a week, particularly after exertion. She had continuous pain in the left side, where a hard lump could be felt 'as long as the hand.'

About a twelvemonth ago she experienced an unusually severe attack of pain and hæmorrhage. She was collapsed and had to keep her bed for over a month. She then went to a hospital and was advised to go on to the Cancer Hospital. This she did, and was admitted there in October 1884, remaining until February 2, 1885, four months in all. From the physician under whose care she was whilst in there the following notes were kindly communicated: No family history of cancer; much hard work and mental trouble. Symptoms of two years' duration. Pain chiefly in hypogastrium, also in back and down the thighs. Some discharge. The examination revealed little intravaginal cervix; the body of uterus formed a hard mass, filling up the pelvis, and was fixed. The margin of the os uteri was healthy.

During her stay in the hospital she had two severe attacks of abdominal pain, with tenderness in hypogastrium and febrile symptoms. After the second of these, on December 22, 1884, the house surgeon noted, on examining per vaginam, a large fluctuating mass like the membranes. The parts very hot. The physician appends to his note, 'I am afraid we looked on the case as a routine one.'

The patient states further that whilst she was in the Cancer Hospital the lump in her left side nearly disappeared. After leaving, these attacks of pain occurred after any exertion. She had a constant discharge of a foul odour, and pain in the womb and back. The bowels were very confined and there was a constant desire to defecate, much straining at stool being present.

Owing to a fall and injury to her ribs, she was admitted to the Middlesex Hospital on September 1, 1885. Her statement was that whilst straining at stool she felt something come down, and found a swelling protruding from the vagina.

On admission she presented a piteous spectacle. She was emaciated, sallow, her face ecchymosed from the fall, lying on her side, groaning and complaining of severe abdominal pain. She was much collapsed; the lips blanched; pulse 108, small. On examination a swelling, the size of a small fist, was found protruding from the vulva, accompanied by much muco-sanguineous discharge.

The tumour appeared to be very sensitive, the patient crying out on the least touch. Chloroform was therefore administered, and the growth returned into the vagina. The patient was rallied with brandy and appropriate nourishment and kept in bed.

Before returning the tumour into the vagina a careful examination was made, and the conclusion arrived at that a fibroid growth on the interior of the fundus had inverted the uterus. The uterine sound could only be passed up half an inch beyond the cervix uteri, and no fundus uteri could be detected above the pelvic brim on conjoined manipulation. Efforts at restitution having failed, the growth was removed with the écraseur, the patient subsequently convalescing without a single drawback. Dr. Edis insisted upon the necessity of extreme care in diagnosis before condemning any patient as suffering from cancer. For over twelve months this patient was practically awaiting death, and had it not been for the fall and injury to her ribs necessitating admission to the hospital would probably have gone on still longer unrelieved.

Mr. LAWSON TAIT said that, as no human being was free from mistakes, nor could ever be, and as it was perfectly certain that we learned far more from our blunders than from our successes, it was a matter of regret to him to see people so thin-skinned about having their mistakes alluded to. He for one had endeavoured to make himself as little sensitive as possible on this subject, and could always hear with considerable equanimity a discussion on any of his own blunders. It certainly was very surprising that a case of this kind should be maintained in a special hospital for

cancer for four months when the note on the case distinctly stated that the margin of the cervix could be felt quite healthy. But it was still more surprising that it should be sent by a special officer at St. Bartholomew's Hospital to the Cancer Hospital under the belief that the disease was malignant. Perhaps it was regarded as 'a lump in the womb of no great consequence.'

The PRESIDENT remarked that it seemed almost incredible how such a mistake could have occurred as that mentioned by Dr. Edis in the case he had just recited. No doubt sometimes cases of sloughing polypi, intra-uterine or fibroid tumours might at first sight simulate malignant disease. The fetor arising from the sloughing mass, the continued offensive discharge, with consequent loss of flesh and strength, and the jagged, irregular feel of the mass on digital examination, all these might in careless hands be mistaken for malignant disease. But the history of the case, closer examination of the symptoms, above all careful digital examination, revealing as it would do a perfectly healty ring of cervix with a mass within round which the fingers could pass, all this marked off with unerring precision cases of cancer from those of the kind under discussion, and he thought that only gross carelessness could confound the two or make such a mistake possible.

Dr. HEYWOOD SMITH exhibited the ovaries of a single woman, aged 24, that he had removed by abdominal section two days previously. For three years she had suffered from profuse hæmorrhagia, the period lasting about fourteen days. The operation presented unusual difficulties, as both ovaries were adherent deep in the pelvis. The right one was first dealt with. It was adherent to intestine and uterus; the oviduct passed directly outwards and was adherent to the pelvic wall. The vermiform appendix was adherent to the right corner of the uterus. The left ovary was enucleated with even more difficulty. It was closely adherent to the intestines, which were themselves involved in adhesions, which though friable felt hardish. The intestines in the neighbour-

hood were almost purple with congestion, and some flakes of lymph were scattered about. This ovary contained a thin-walled cyst the size of a small orange. It and the oviduct were removed. The oviduct was fused at its fimbriated extremity with the ovary, and on being laid open was found to be thickened along its whole length to the extent of about a quarter of an inch, and it was this condition probably, as pointed out by Mr. Lawson Tait, that gave rise to the hæmorrhage.

Dr. BANTOCK exhibited a ruptured papillomatous cyst of the right ovary, which he had removed a week previously from a single woman aged 36. The patient first came under his notice five years ago. The tumour at that time nearly reached the umbilicus, was freely movable, and was diagnosed as ovarian. He did not see the patient again till about a month ago, when the abdomen was considerably distended by a well-defined tumour which extended into the epigastrium. The history was interesting. Two years ago she was thrown from a carriage, and was very ill for two or three days. After this the abdomen became quite small. During the last six months it again increased in size, rather rapidly. On admission into the hospital about a fortnight after seeing her for the second time, it was evident that rupture had taken place again, for there was no defined tumour; but there was a large quantity of fluid free in the peritoneal cavity. On opening the peritoneum this fluid escaped, and the tumour came into view in the lower abdomen, below the level of the lower angle of the wound. There were some filamentous adhesions to the opposite (left) Fallopian tube and intestines and in the pelvis, but there was no difficulty in turning out the tumour and securing its rather short pedicle.

The left ovary (which was also exhibited) was in an early stage of cystic degeneration, and furnished a good example of the mode of origin of at least some forms of ovarian tumours—that is, it showed that the cysts originated in the Graafian follicles. The case was, moreover, interesting as bearing on the question which is now under the consideration

of a committee of the Society, viz. on the relation between ovulation and menstruation. The menstrual periods recurred every three weeks, lasting four to five days, but there was no evidence of recent ovulation. The ovary contained a corpus fibrosum as large as a field bean. The patient has made a good recovery.

Dr. Bantock then exhibited a specimen of dermoid cyst of the right ovary, which he had removed in the afternoon from a single woman aged 30. The patient was aware of enlargement of the abdomen for two or three years, but was not aware of any tumour being there until in April last she felt a small painful and tender lump on the left of the middle line and below the level of the umbilicus. This was readily determined by the sound to be the uterus, which was drawn quite out of the pelvic cavity. It appears that the tumour had become adherent, at an early period, in the bottom of Douglas's pouch, on the right side, and that, as it increased in size, it drew up the uterus. The adhesions were very intimate and difficult to separate, on account of their long standing, and there was much venous oozing, which necessitated the use of the drainage tube. The cyst contained a very dark grumous fluid, the result of hæmorrhage from degeneration of the cyst wall, and on everting it there was found a piece of true skin of about two inches square, with a long lock of hair growing from it.

A New Operation for Restoration of the Female Perinæum in cases of Total Loss. By R. A. JAMIESON, M.A., Consulting Surgeon to the Imperial Maritime Customs in China.

THE patient, aged forty, height 5 feet 4½ inches, weight 185 pounds, phenomenally fat, of a particularly genial disposition, *presenting no nervous symptoms*, was mother of four children. First confinement passed off without accident. Her second child was born in February 1868; it was very large, weight not noted, and was delivered with forceps. There was much

crushing of soft parts of mother, followed by sloughing and complete loss of perinæum. Ever since there had been much trouble with the bladder, frequent calls to micturate, and incontinence if these calls were not instantly obeyed. ***But there had been no symptoms referable to the uterus except a very slight and occasional leucorrhœa.*** (This fact is worthy of note in the light of the condition to be presently described.) There was frequent defecation, with urgent need to obey the first indication of a call to stool, but no true incontinence of fæces. The escape of flatus was, however, uncontrollable, and this was the most distressing symptom present, as it totally unfitted the patient for society, and made her miserable even within her own family circle. She became pregnant with her third child in 1875, and was delivered with forceps, the doctor in attendance having told her that 'the labour would never terminate without instruments.' She arrived in China in 1882, became pregnant in February 1883, and went on well until July, when I first saw her. Her complaint then was of complete inability to retain her urine.

On examination I found total loss of the perinæum, the lateral walls of the vagina directly continuous with the inner surface of the thighs, without any tangible ridge or line of demarcation whatsoever. The anterior edge of the anus was concave, in consequence of the loss of a portion, represented by a puckered semi-elliptical scar, so that at the first glance the vagina and rectum seemed to form but one cavity. The vaginal mucous membrane, for about one inch from the anus was intimately blended with the anterior wall of the rectum, the recto-vaginal septum appearing here no thicker than an ordinary visiting-card. Above this, the rectum bulged forwards and downwards on pressure, but not sufficiently to constitute a rectocele. The bladder was empty and normally situated. The uterus was somewhat low, but not remarkably so; the os nearly central, cervix pointing slightly backwards, no cervical laceration, slight and quite inconsiderable leucorrhœa. Labia minora tumefied and excoriated; large erythematous patches on internal surfaces of both thighs.

From this date, her clothing was constantly wet, and she suffered much from bronchitis all through the autumn. Being a woman of very active habits, it was impossible to keep her lying down.

Labour began on November 9, 1883, and I was called after twelve hours. The patient was not certain whether the waters had escaped or not, as she was continually straining to pass urine, sometimes successfully, often not. She described the pain as agonising, different from anything she had ever felt. The outlet was occupied by an elastic tumour—the bladder—and behind and above it the head presented in the third position. After emptying the bladder with a soft rubber catheter, I supported its fundus until, under the influence of a dose of ergot, the head advanced sufficiently to put it out of danger. Very speedily the vertex reached the vulvar opening, but, presumably from lack of reflex stimulation (absence of perinæum), the uterus ceased to contract. After waiting half an hour, I extracted the child without any difficulty. Convalescence was fairly rapid.

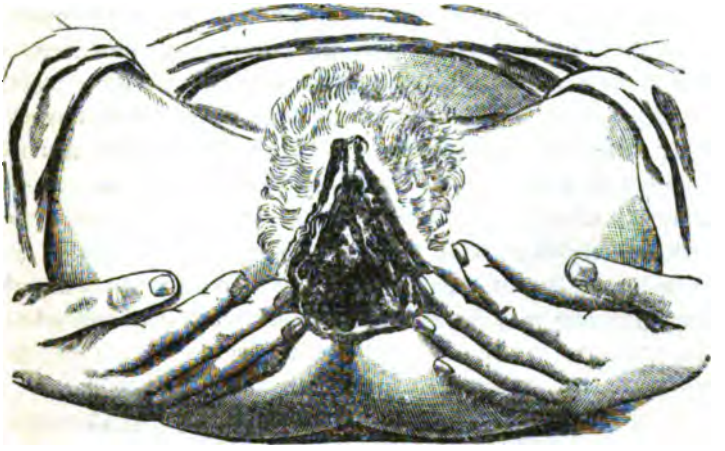
Having determined to be operated on, the patient postponed any action, in consequence of lactation and for various other reasons, until March 19, 1885, three days after the cessation of the catamenia.

It was abundantly evident that no mere denudation and approximation of the sides of the cleft would suffice to remedy the condition. In fact, there was nothing left after the seventeen years during which the condition had existed that could be denuded and simply approximated. The accompanying drawing accurately represents the state of the parts.

The bowels having been emptied by castor-oil and enema, and the patient chloroformed and fixed in the lithotomy position by means of Pritchard's shackles, the vagina was thoroughly douched with a one two-thousandth solution of perchloride of mercury.

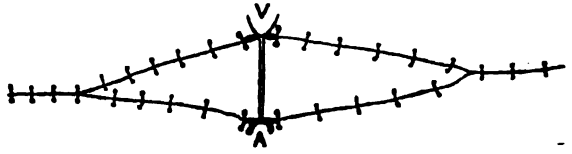
With great difficulty I separated the recto-vaginal septum into two layers for a distance of a little more than an inch, and divided the vaginal portion longitudinally in the middle line, dissecting the mucous membrane of which it was a con-

tinuation, along with a border of the adjacent skin, forwards on either side to the level of the insertion of the labia minora. This was not separated as a strip, but was simply lifted from its previous attachment, to the depth of about 1½ inch parallel to the long axis of the body, its free borders being the line of longitudinal division just mentioned and a curved line drawn about half an inch below the junction of the partly altered vaginal mucous membrane with the skin of the thigh. The horizontal border of each muco-cutaneous flap was transfixed with a long piece of catgut, to the end of which a bit of lead



was attached, and the threads thrown upwards and outwards across the groins. A cutaneous flap in the shape of an isosceles triangle with convex apex was now raised from each ischio-rectal space, the base corresponding in position to the line of junction of the skin and mucous membrane, and in length to the region denuded. Each flap was four inches long. These were lifted with about a quarter of an inch of subcutaneous fat, and were dissected upwards and outwards to a line parallel to their bases, but a quarter of an inch external to them and a quarter of an inch deeper. There was free venous bleeding, but only one vessel (in the left vaginal wall) required torsion. The raw surfaces of the muco-cutaneous flaps were next stitched together with a cambric

needle and fine catgut along their line of longitudinal division, to form the lower portion of the new posterior vaginal wall. Care was taken to unite their edges to a sufficient depth to secure union and to form a firm ridge along their line of junction. The new perinæum was formed by carrying a continuous catgut suture from side to side in the depth of the tissues, following lines about one quarter of an inch internal to the dihedral angles formed by the inclination of the cutaneous flaps to the subjacent layers of areolar tissue. The anterior edge of the rectal mucous membrane was drawn down and firmly stitched behind to the new perinæum, and the restored posterior vaginal wall was secured to its anterior edge. The cutaneous flaps were then loosely replaced, leaving on each side about an inch and a half between their apices and the apices of their former beds. Four sutures (two on either side, one anterior and one posterior) were carried deeply into the perinæo-crural angle so as to ensure the formation of a fold in this situation. A line of sutures was carried along the edges of the flaps, and the borders of the gap left were drawn together. The appearance immediately after operation may be thus diagrammatically represented :—



The vagina was well douched with perchloride solution; half a grain of morphia was injected, the bladder was emptied, and the patient removed to bed and surrounded with hot bottles. The operation lasted a few minutes over an hour. The patient rallied well from it, and complained of but little pain.

The temperature reached 101·5° on the evening of the second day, and after this oscillated between 98·4° and 100° until the eleventh day, when it became permanently normal.

The catheter was used twice daily until the nineteenth

day, when bladder and bowels were relieved together. This first action of the bowels was induced by castor-oil. The tongue had begun to load on the sixteenth day.

Until the ninth day the vagina was syringed and all the parts concerned carefully washed morning and evening with a half per mil. solution of perchloride of mercury. After this recently-boiled water, cooled to 115° Fahr., was used for these purposes. The lines of incision and their neighbourhood were kept plentifully covered with salicylic cream until the ninth day, when, as it caused severe smarting, it was changed for calamine ointment; and this in turn was replaced a little later by a dusting powder of oxide of zinc.

Half a grain of morphia was injected subcutaneously morning and evening until the twelfth day, and at night only from that date until the twentieth day.

No food whatsoever was administered until the fifth day, when a coffee-cup of chicken broth, boiled with bread, was allowed.

Throughout there was little or no pain, but, of course, much discomfort.

On the third day, the sutures closing, the external, horizontal portion of the operation wound on each side gave way, and the fat beneath was found to be sloughing. The process was at an end in four days, during which time a great deal of subcutaneous fat separated; but the flaps were hardly affected, their tips only being lost.

On the third day, also, the patient observed that wind passed through the anus only.

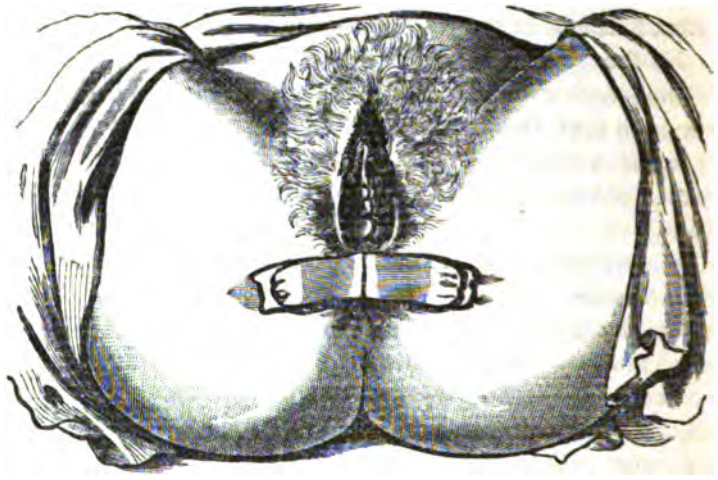
On the eighth day there were several rushes of leucorrhœa, which caused intense smarting as it passed over the wounds. This discharge continued profuse for several days, when it diminished considerably.

The perinæal region was examined on the fifteenth day, when the artificial structure was found in a perfectly satisfactory condition, the sloughing process not having approached it. Firm pressure on it from within the vagina showed it to be dense and resistent.

The patient began to move about her room on the twenty-second day. Healing was complete on the twenty-eighth day. A fortnight later the catamenia appeared.

On May 19 a careful examination of the parts was made by Dr. Reifsnyder and myself. The accompanying drawing gives a tolerably accurate idea of the appearance they present.

The patient is easily fatigued by exertion, but she is conscious of no local pain or downward pressure. On the contrary, she experiences great comfort from the unaccustomed



support, though the presence of a structure, to the loss of which she had become habituated, still gives her a strange sensation. When looked at while she lies on her back, with the thighs widely separated, the vulva is seen to be of normal size, with a thick, soft, and slightly concave posterior border. From the verge of the anus to the anterior edge of the perinæum measures seven-eighths of an inch. The new perinæum presents an almost perfectly natural appearance, a faintly depressed line marking the union of the two sides. Its thickness, measured with calipers, from the anterior border of the anus to the point directly in front of this within the vagina is half an inch. The uterus is in its normal

position. When the patient coughs forcibly—the finger being inserted into the rectum—there is a strong contraction of the sphincter; the anterior wall of the vagina descends slightly, but is arrested by the perinæum at its most posterior point; and there is no escape of urine, though the bladder has not been emptied for a couple of hours.

Such is the net result of the operation, which seems to be sufficiently satisfactory. How the artificial perinæum will bear the strain of a labour, should such a contingency happen, remains to be proved. There ought, however, to be little or no difficulty in reuniting the borders, supposing a rent to occur, as there is now ample material.

In the 'British Medical Journal' (1883, i. 952) Professor Pallen, of New York, describes an elaborate operation for restoration of the totally lost perinæum. He raises flaps from the ischio-rectal region, turns them upwards and inwards, with the skin surface towards the vagina; unites their edges with sutures, which include the vaginal mucous membrane, and then approximates the denuded surfaces left on the two sides. A great mass of tissue is thus made to replace the lacking perinæum, and, no doubt, very efficient support is supplied for the relief of all degrees of procidentia. He alludes to more than seventy successful cases, but he particularises only two—one in a woman aged sixty-three, the other where the patient was seventy-one. Even after making full allowance for stretching and gliding of the surrounding skin, I cannot but think that this extensive gathering up of tissue, the soft parts (according to the description) corresponding to each ischial prominence being united in the middle line, must seriously interfere with locomotion, as well as with other functions which a married woman still within the child-bearing period may be called upon to perform.

The gliding operation that I describe is not open to this objection. The amount of scar left is inconsiderable. There is no interference with the natural movements of the thighs, and the manufactured perinæal body is of considerable and apparently sufficient bulk and strength.

Dr. FANCOURT BARNES said that at the end of last May Mr. Lawson Tait had kindly shown him his method of restoring ruptured perinæums. Since then he had operated on eleven cases of ruptured perinæum by Mr. Lawson Tait's method in the Chelsea Hospital for Women. It seemed to him that Dr. Jamieson's operation was almost identical with Mr. Lawson Tait's. The taking the flaps from the ischio-rectal region was a detail. The real value of the operation arose from the splitting of the recto-vaginal septum through the deep fascia, together with the insertion of the sutures within the margins of the wound thus created. Since seeing Mr. Lawson Tait do the operation just mentioned, he had operated on eleven cases in the same way with most satisfactory results. The advantages he had found it to possess over the old method by denudation were:—firstly, rapidity; it was difficult to take longer than eight minutes by Lawson Tait's method, whereas he had seen some operators occupy fifty minutes and upwards with the old method; secondly, increased solidity of the new perinæum; thirdly, absence of pain after the operation; fourthly, the facility with which the bowels could be kept acting from the day of the operation onwards. In addition to the above there were other minor ones, all going to make up a sum total greatly in favour of Lawson Tait's operation. Not the least of these was its equal adaptability to all varieties of rupture.

Dr. IMLACH observed that, though there was only one way of performing ovariotomy, there were numerous methods for repair of the lacerated perinæum. The modifications of Baker Brown's operation chiefly consisted in the removal of a larger portion of the vaginal mucous membrane, and in utilising the strip instead of cutting it away. Some surgeons vied with each other in the strength of the material employed for the deep sutures, one recommending thick iron wire, and another doubly thick silver. But tension always set up suppuration, and would cause failure of union even when the sutures were inserted, as recommended by these authors, an inch from the edge of the wound. Silkworm gut or fine silk,

inserted close to the edge, was far better. In a recent rupture nothing else was required, and even cotton thread would serve. But in an old case, with much cicatrisation, it was sometimes impossible to approximate the cut surfaces without tension, and when the operation was successful there was apt to be complaint of a feeling of constriction. Since the inutility of the perinæal body as a pelvic support had been demonstrated in England long ago, though only recently in the United States, its repair after slight laceration was probably not so frequently performed, but when the sphincter ani was wholly or partially torn, repair was necessary to the woman's comfort. A substantial perinæum could be made, without the use of deep sutures, by the following method. A flap is taken from each labium, exposing, when possible, the torn fibres of the sphincter. These flaps are not cut away; the left one hinges outwards to the skin, the right one hinges inwards to the vagina, and both flaps are trimmed at the anus. A strip from the recto-vaginal septum is thrown outwards. The free edge of the right flap is next drawn across to the left labium and attached by a few fine sutures to its cut surface—that is *one* new perinæum. Then the left flap is drawn across to the right labium and attached by fine suture to its cut surface—that is a *second* perinæum, and the cut surfaces of the two flaps are in apposition without tension. A single stitch is passed through their anterior edges to prevent infiltration of vaginal secretions, and another unites the recto-vaginal strip to the flaps posteriorly. The depth and length of the new perinæum are obviously determined by the depth and length of the flaps. The posterior trimming is for the purpose of bringing the edges of the sphincter together. After the ordinary operation the so-called new perinæum is really a median cicatricial line, while after the operation above described the perinæum is a substantial body with no cicatrix in the middle line, and more capable, therefore, of withstanding the violence of subsequent parturition.

Mr. LAWSON TAIT said that first of all he had to acknowledge thankfully the singularly gratifying remarks which had

just been made by his friend Dr. Fancourt Barnes. So far as he could see from the description of an operation it was very difficult to follow, the operator had succeeded in doing by a very roundabout way what Mr. Tait's own operation did with great simplicity. The merits of this operation were, so far as now a very large experience enabled him to conclude with perfect certainty, first of all that, as it removed no tissue at all, the patient had a much larger, more solid and sustained perinæum than could be obtained in any other way. In the second place, as the operation merely placed the parts in the condition in which they were at the time of the tear, repair must of necessity take the most natural form; by the simple process of slitting the septum in the direction of the original cicatrix very wide raw surfaces were obtained, which were united by three or four deep sutures in the easiest and most rapid way possible. It was, as Dr. Barnes said, difficult to occupy more than eight minutes in the operation, and usually it did not occupy more than three or four in Mr. Tait's own hands. Another advantage—not a great one certainly, but still one of some note—was that some weeks or months after the operation it was impossible to tell that the patient had ever been injured, and this was due to the fact that the stitch holes were made within the skin wound and not through the skin itself. As to the views expressed by Dr. Imlach, he must coincide with Dr. Bantock in differing from them from beginning to end. He had had a very large experience with the perinæum, in fact the success of his special proceeding had brought him an enormous practice in that particular operation, so that he was rarely without three or four cases; and he had never failed save in one instance, where a previous operator had removed apparently a very large amount of tissue. He had operated upon many cases in which other operators had secured a bridge across, but had left holes on the wrong side of the sphincter. With his operation such a result was impossible.

Dr. HEYWOOD SMITH said he quite corroborated what had been said by Mr. Lawson Tait, Dr. Edis, and Dr. Fan-

court Barnes as to the rapidity and success of the new operation, and since Mr. Lawson Tait had shown him the operation in the theatre of the Hospital for Women, he had invariably operated after that method, and saw no reason to revert to the old plan.

Dr. EDIS also bore testimony to the advantage of Mr. Lawson Tait's method of operating. It took far less time, and if only done properly formed as complete and useful a perinæum as the more usual and tedious operation. He (Dr. Edis) had resorted to Mr. Tait's operation on several patients, the results being perfectly satisfactory.

Dr. BANTOCK had given a great deal of attention to the subject of the operation for ruptured perinæum. With regard to the operation, the description of which had just been read, he had to confess that he had the most hazy idea of the exact mode of procedure adopted. It was exceedingly difficult to understand any description of an operation of this character without an opportunity of studying it. He failed to see of what advantage the use of an antiseptic solution had been in Dr. Jamieson's case. It certainly did not prevent suppuration and even sloughing. For his part he had never employed anything of the kind, and he had never had a case of suppuration extending beyond the track of a suture that had been tied too tight, but had invariably obtained union by first intention. He agreed with Dr. Imlach in saying that he could not comprehend how a flap of four inches was obtained. He also agreed with him in deprecating the use of a *powerful* suture for the deep stitches, with the intention of keeping the raw surfaces together in this operation. Having stated his agreement with Dr. Imlach on these two points, he was obliged to dissent entirely from him on the other points raised. His cases did not break down, for he had not had a single case of suppuration in his practice. The operation as practised by him was not a painful one, for he had now entirely discarded the use of opium, and his patients suffered less than at the time of the rupture. Dr. Imlach threw discredit on the silkworm gut as a material for suture; but his own experi-

ence, now extending over ten years, had continuously tended to confirm him in his opinion as to its advantages over every other kind of suture. Nor was there any difficulty with the action of the bowels in the operation for rupture through the sphincter as practised by him. Every man was apt to think his own operation the best. He, however, would not go so far as that with regard to his mode of performing this operation, but he was bound to adhere to a method which had not yielded him a failure. He could not but think that the necessity for the use of a drainage tube was a fatal blot on the method which Dr. Imlach commended for our adoption. He thought it of the utmost importance that in this operation—as indeed in every operation—perfect apposition of the raw surfaces should be secured if we wished to obtain union by first intention.

Dr. Fancourt Barnes spoke of the 'old' operation and contrasted it with the new. He presumed the use of the quilled suture was meant by the expression. He (Dr. Bantock) believed that this mode of suture was answerable for all the cases of suppuration and sloughing he had seen under the hands of the late Mr. Baker Brown, whose expertness could not be questioned. It was exceedingly difficult to secure these sutures without an excess of tension from swelling of the included tissues. The consequence was, as he had seen happen, that when after forty-eight hours the sutures were cut, the natural resilience, aided by the swelling of the parts, tore open the deeper portion of the wound, and but for the more superficial sutures which were also invariably used, the whole wound would have broken down. Hence the resulting perinæums were often thin and membranous.

He was indebted to the courtesy of Dr. Fancourt Barnes for an opportunity of seeing him operate on a case of partial rupture by Tait's method. While the procedure was different the result was practically the same. Whereas, in Tait's method, the needle was introduced into the raw surfaces close to the skin, in his method about a quarter of an inch of skin

was included. The direction of the sutures was precisely the same.

He would not enter into the question of the existence or non-existence of a perinæal body, raised by Dr. Imlach, further than to say that, as between Thomas and Emmet, he agreed with the former in recognising its existence, and was of opinion that Emmet failed to sustain his point.

Dr. BARNES wished to say a few words on the history of perinæorrhaphy. Before Baker Brown, Marion Sims, and others came upon the scene, Charles Brooke had long worked out the principle and perfected a successful proceeding. He prepared the surfaces by denudation, and brought them together by silk sutures, and kept them to by his beads. The design of the beads was to secure adaptation of the deep or middle part of the wound. To secure the edges he sometimes put superficial sutures on the skin, and to the mucous membrane in the vagina. He had also worked out a successful treatment of vesico-vaginal fistula, having designed and made his own instruments, by one of which he could tie a knot at the fundus of the vagina, at a distance of several inches from his fingers, without the use of a speculum. Brooke was a man as remarkable for his modesty and want of self-assertion, as for his ingenuity and originality of mind, and so his great merit had been overlooked. Dr. Barnes spoke from personal knowledge, having seen Brooke operate forty years ago.

He hardly thought it necessary to say that he thought the perinæum was designed by Nature to serve a useful purpose, and that when it was impaired our business was to restore it. The outlet of the pelvis was guarded by two valves: one, the upper and anterior, formed of the uterus, bladder, anterior wall of the vagina, and connecting tissues; the other, posterior and lower, receiving and supporting the anterior valve, constituted by the posterior wall of the vagina, the perinæum, and connecting tissues. It was easily seen that the lower or hinder valve aided materially in supporting the anterior valve. In some cases of retroversion,

prolapse, and retroflexion of the uterus, a pessary could not act efficiently until the perinæum was restored, so as to support the pessary, which then would support the uterus.

He could not agree with Dr. Imlach in inserting the sutures near the edges of the wound. He believed Dr. Thomas's plan of taking the hindermost and deepest sutures well back, to make the needle sweep round so as to complete the broken circle of the sphincter, was correct; and since Dr. Thomas had shown him this, some years ago at St. Thomas's Hospital, he had adopted it. His own results in private practice had been entirely successful. In St. George's Hospital failures had occurred from sloughing, due to hospital influences.

Turning to Dr. Jamieson's very interesting case, he was sure the Society's thanks and appreciation would be enhanced when it remembered the conditions under which the author worked. Practising in Shanghai, he had to rely upon himself alone, to elaborate out of the writings of others, and still more out of his own experience and study, the ingenious and successful operation recorded. It was an excellent example of the principle of splitting the tissues to make raw surfaces instead of paring. In an unusually difficult case success had vindicated his practice. This principle must now be considered to be fairly established by the remarkable success of Mr. Tait. He himself had hitherto followed very nearly the method of Charles Brooke, discarding the beads, and the bits of bougie or splints which had been introduced by subsequent operators. Henceforth he should certainly adopt Mr. Tait's principle.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, OCTOBER 28th, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 32 Fellows, 4 Visitors. The following gentlemen were elected Fellows of the Society:—Dr. J. B. Edis, Dr. W. McGeagh, Dr. W. Erskine, Dr. W. S. J. Scott, Dr. H. T. Rutherford, Dr. C. H. Gamble, Dr. G. J. Engelmann, Dr. W. H. Byford, Dr. W. H. Baker, Dr. P. F. Chambers, Dr. P. F. Mundé, Dr. E. C. Dudley, Dr. H. R. Bigelow, Dr. J. P. Boyd, Dr. W. M. Polk, Dr. J. W. Nosebrugh, Dr. A. Vanderbeer, Dr. R. Battey, Dr. J. B. Hunter, Dr. A. R. Jackson, Dr. C. Jewett, Dr. A. J. C. Skene, Dr. W. G. Wylie, Dr. C. J. Wright, Dr. J. H. Hough, Dr. J. H. Simpson, Dr. R. A. Jamieson, Dr. F. Imlach.

The following gentlemen were proposed for election:—Dr. James Hunter Condon, Cawnpore, India; Dr. William T. Lusk, New York; Dr. J. A. Mulville Thomson, Hemel Hempstead; Dr. Charles Rotherham Walker, London; Dr. Frederick Augustus Newton Bateman, London; Dr. Frederick William Devereux Long, London.

Dr. BANTOCK exhibited the following specimens:—

1. The uterine appendages from a married lady aged 44, who had had one still-born child at eight months and several miscarriages. The principal symptoms were constant pain in the left ovarian region, dysmenorrhœa, and extreme dryness of the central third of the tongue—like the tongue of a typhoid fever case—for the last three years. On both sides there were adhesions of the tube to neighbouring structures

and the ovary, most marked on the left side. The tubes were not enlarged, but hardened; the ovaries were rather small. The patient went home a few days ago free from pain and with a perfectly healthy, clean tongue.

2. The appendages of a married woman aged 35. The patient had had one child (January 1884) and was apparently quite well till May last. In that month the period came on at the proper time with great pain and in great excess, and she had a continuous, more or less copious, hæmorrhagic discharge till August 1st. For over two months she lay in the Military Hospital for Women at Colchester with varying degrees of pyrexia. When first seen, about the middle of August, there was a tumour in the right side of Douglas's pouch, pushing the uterus forward, as large as a small cocoa-nut and very tender. She was admitted into the Samaritan Free Hospital on its reopening, and the operation was performed on the 15th inst. The omentum was adherent at the brim of the pelvis anteriorly, particularly about the level of Poupart's ligament on the right side, and had to be separated. The left tube was found as large as the little finger, very hard, and very adherent to the neighbouring structures. It was removed along with the ovary, the two being intimately adherent. On the right side there was a cyst as large as a goose's egg with very friable walls, which gave way while separating the universal adhesions, giving exit to a thick, dark, grumous fluid, the result of broken-down blood-clot. It was removed along with the ovary, which was closely adherent to it, and found to be the right tube dilated into a cyst by blood effusion. The bed of this cyst consisted of peritoneum very much thickened by the inflammatory process. The escaped contents of the cyst and the blood from the torn adhesions were well washed away by pouring tepid water into Douglas's pouch, and a drainage tube was inserted. The patient was now quite well.

3. The appendages removed from a single lady, aged 26, who had been an invalid for several years, suffering from constant pain and severe dysmenorrhœa. On examination

the uterus was found pushed back against the pubes, and Douglas's pouch occupied by a confused mass which, however, did not rise above the level of the fundus uteri. The operation was performed on the 22nd inst. The left tube and ovary were very adherent, the former very much enlarged and hardened. While this was being separated it was rather disconcerting to see sebaceous matter, very much resembling the product of a dermoid cyst, coming up from the pelvis. This was subsequently found to have come from a cyst on the right side, which had been accidentally ruptured in breaking down the adhesions connecting it with the appendages on the left side. On the removal of the appendages of the right side this cyst, which was as large as a hen's egg, was seen to be connected neither with the ovary nor the tube, and its real nature had not yet been made out. This tube was in the same state as the left one. There was rather free oozing from the torn surfaces, and after a good washing out of Douglas's pouch with warm water a drainage tube was inserted. The patient was quite convalescent.

4. Two large parovarian cysts removed in the afternoon from a single woman, aged 45, which he was anxious to show in their recent state, because the condition of one of them was much better seen than it would be after a day or two. That the cysts were parovarian would at once be seen from the facility with which the cyst proper could be separated from its peritoneal envelope and from the fact that the ovary, drawn out to a length of three inches, remained with the latter. But the point to which he specially wished to direct attention was that on the interior of one of the cysts there was already a considerable sprouting of papilloma. It had been stated on very high authority that it was sufficient to tap these parovarian cysts to ensure their disappearance and cure. His experience had led him to dissent entirely from this teaching. Some ten years ago, in the case of a girl aged 19, after removing a large ovarian tumour from the left side he pricked and evacuated a small parovarian cyst on the right side as large as a hen's egg. This was done in accord-

ance with the teaching at that time of Mr. Spencer Wells. In five months the poor girl returned with an encephaloid mass growing from the site of the parovarian cyst, which it was impossible to remove, and the patient died. Had the cyst been removed instead of being merely evacuated, the patient might have been still alive. He had also removed a parovarian cyst that had been tapped seven times. Moreover he had frequently seen papilloma in parovarian cysts. In this case also, in addition to the papilloma, degeneration of the cyst wall had already begun; and, in reply to the President, he stated that, while in the one case the fluid presented the distinguishing characters of slight opalescence and low specific gravity, in the other the fluid evidently contained some blood elements derived from small hæmorrhages from the degenerated portions, the fluid consequently presenting a dirty appearance. He thought it a matter of the utmost importance that the teaching from which he dissented should be met by these facts, and he regarded the removal of the tumour by the radical operation as the correct and most scientific practice.

He asked to be allowed to refer to an interesting point in connection with the case of papilloma he exhibited at the last meeting. On the left side the patient had a large inguinal hernia, the internal opening of the canal readily admitting the index finger. With the view of effecting a radical cure, he stitched the pillars of the ring together with a continuous suture of silkworm gut, and he had reason to believe that his object would be effected. The patient left the hospital on the previous day.

Dr. FANCOURT BARNES showed the kidneys from a patient, aged 23, II.-para, who had died in the Chelsea Hospital for Women from albuminuria. She was admitted from the out-patient department with œdema of the face and three-quarters albumen in the urine. She was five months pregnant. Premature labour was induced, but the urine remained almost solid with albumen and she died three days afterwards. The kidneys were large and white; the other

organs healthy. She had had albuminuria in a previous pregnancy. The case illustrated the importance, in such conditions, of losing no time in emptying the uterus. Had this been done earlier her life might have been saved. No time was lost at the Chelsea Hospital for Women in doing this, as the labour was provoked on the evening of the day of her admission. Although the patient died from the albuminuria, there were no convulsions. He regarded the case as one of nephritis resulting from the high tension of pregnancy.

Dr. BARNES observed that this case was probably one in which the organic change of the kidneys had been developed during the preceding pregnancy, and continuing during the non-pregnant state, had become confirmed and aggravated in the pregnancy, which came to a fatal termination. The case illustrated forcibly the necessity for inducing labour as soon as albuminuria was fairly established. If the high tension of pregnancy was allowed to go on for months until either convulsions or labour at term took place, the probability was that the kidney would be irretrievably damaged. He had several times discussed the clinical questions in St. George's Hospital in consultations with Dr. Dickinson. His opinion was emphatic against delay. There could not be a more ignorant dogma than, 'Trust the disease, and let the pregnancy take care of itself.' The disease depended upon the pregnancy; and in most cases the only hope of recovery lay in the removal of the cause.

Dr. GRIGG congratulated Dr. Fancourt Barnes on bringing this very interesting case before the Society. These cases of acute albuminuria of pregnancy were not frequent, but when met with in hospital practice the disease had been allowed to proceed to such lengths that they, according to his experience, invariably proved fatal. The several cases which had come under his notice had all been under medical care prior to admission into the hospital. The extreme gravity of the cases not being recognised, pregnancy was allowed to advance until the sixth, seventh, or eighth month,

when the patient was sent into the hospital in an almost hopeless condition. Dr. Grigg was strongly of opinion that where marked signs of albuminuria showed themselves early in pregnancy, and the urine was loaded with albumen and did not yield to treatment, the induction of labour should not be delayed, and was glad to hear Dr. Robert Barnes give his authoritative approval of this procedure, as he felt it was the only treatment to give the patient a chance of life. These cases might or might not be coupled with eclampsia. He had seen eclampsia with large white kidneys, and had seen cases succumb with the same condition of the kidneys without a sign of any convulsions. There was no special form of kidney affection which could in his opinion be called an eclamptic kidney.

Dr. BANTOCK remarked that the question of albuminuria in connection with enlargement of the abdomen, whether from pregnancy or tumour, was a very important one. It had fallen to his lot to observe this condition in several cases of ovarian tumour and in one of large uterine fibroid, and it was remarkable how soon the albuminuria disappeared on the removal of the pressure. In one of the ovarian cases the albumen disappeared after a preliminary tapping. In the case of the fibroid tumour there was general anasarca along with a severe form of albuminuria. Within twelve hours there was only a trace of albumen, and within three days the anasarca had disappeared. If, then, a slowly growing tumour could produce such a result, it was much more likely to follow the rapid growth of a pregnant uterus. He could not but think that in severe, continuous, and increasing albuminuria the induction of abortive or premature labour would, in certain cases, be a perfectly justifiable if not necessary proceeding; for it was very probable that interference with the circulation of the organs, such as to produce severe albuminuria, must have a serious effect on the nutrition of these organs, and that structural change must ensue—in fact, such a condition as was found in the case before us.

Dr. ROUTH said he had the highest possible opinion of

Dr. Robert Barnes's knowledge in gynæcological subjects, and he always looked with respect upon his opinions, but on the present occasion (if he had understood him rightly) he must differ from him altogether. The doctrine now enunciated, that if a woman evinced symptoms of albuminuria in her first pregnancy, to say of necessity that Bright's disease would go on developing with each successive pregnancy, and therefore premature abortion must be induced, he entirely dissented from. It was indubitable that not only traces of albuminuria but even considerable quantities of albumen might be found in the urine of persons without a trace of Bright's disease. A blister, a course of mercury, a sudden chill, cystitis, &c., might all induce albuminuria, but this was not Bright's disease. He believed the albuminuria was due to pressure on the kidney and its vessels. It was especially noted in cases where the contents of the uterus were unusually voluminous, especially when owing to much liquor amnii. Nay, the very *eclampsia* that occurred, he believed, was often due to this cause. He had already mentioned elsewhere a case of long and continued eclampsia during labour, in which the prolapsed chord had slipped out, but the moment he placed the woman on her belly to induce its resuming its normal position the fits stopped and did not recur. He explained this by the removal of pressure, and Dr. Bantock had also noticed that large fibroids often induced albuminuria, which at once disappeared on the removal of the tumour, from the cessation of pressure, as he (Dr. Bantock) also believed. He would therefore greatly qualify Dr. Barnes's statement. If the urine almost completely coagulated with heat, *i.e.* if the quantity of albumen was excessive, if the specific gravity was low, if the *upper* extremities and *face* swelled, if casts were found in the urine, and if the quantity of urea excreted was below what it ought to be in the twenty-four hours, then, and *then only*, could the idea of inducing abortion be considered and advised. But if only albuminuria were present and in moderate quantities, if urea was excreted sufficiently, if only the *lower* extremities were swelled, and no

casts found by the microscope, that was not a case for interference. True, it should be watched, but the pregnancy allowed to run its course. No medical man had a right to stop that pregnancy and prevent a child and heir from being born to those who wished it, except in very serious and very exceptional cases.

DR. BARNES was prepared to accept some of Dr. Routh's qualifications, but was still convinced that the proper course was to terminate the pregnancy whenever albuminuria was at all established. It was an error to suppose that albuminuria at first implied disease of the kidney. It began simply as the result of the high nervous and vascular tension of pregnancy; but the kidney could not long bear this pressure without damage. That the kidney might escape damage if relieved in time he had, in the course of an experience extending over many years, seen abundant proof. He could speak to several cases whom he had attended for albuminuric eclampsia twenty or more years ago, who escaped trouble in subsequent pregnancies, and made perfect recoveries.

Mr. LAWSON TAIT rose to ask a question for information as to whether Dr. Fancourt Barnes's case might not rather be considered as one of pregnancy occurring during the course of albuminuria, rather than the ordinary albuminuric condidition which occurs in pregnancy, characterised by eclampsia, and he was not quite so sure that the same practice might be adopted as the rule in the two classes of cases. Certainly the kidneys which were presented by Dr. Barnes presented altogether different appearances from those which he had uniformly found in post-mortem examinations after death from eclampsia. Those were soft, pliable, engorged with blood, and on examination with the microscope showed marked hæmic infarction. The kidneys showed by Dr. Barnes were, on the contrary, large and white, and the objects of long-standing disease. There could be no doubt at all that Dr. Barnes's views concerning the necessity of immediately emptying the uterus in puerperal eclampsia formed the accepted rule. What he wanted to know was whether Dr. Barnes would always

recommend the same treatment to be carried out when pregnancy occurred during the course of chronic kidney disease.

Dr. FANCOURT BARNES, in reply to Mr. Lawson Tait, said that the patient had had no eclampsia. He did not understand what was meant by the kidney of eclampsia. He regarded the large white kidney as the product of nephritis recurring in successive pregnancies, and caused by them. He had no fixed rule as to the induction of premature labour. This must depend on the gravity of the symptoms.

Dr. J. E. BURTON showed the uterine appendages from a case of absence of uterus and vagina. 'The patient from whom the specimens were taken first came under notice about two years ago. She was then 23 years of age, was suffering from intense and continuous headaches, pains in the pelvis and elsewhere, and she had never menstruated. On being informed that something was wrong with the external genitals, I made a digital examination, and succeeded at last in determining that the vagina was certainly absent, that the uterus was almost certainly so, and that the ovaries were present, although I could not determine their presence by physical examination. I inferred this from the general vascular fulness and pains, and also from finding the urethra large and open. I concluded that the urethra would not have been in the condition it was in if there had been complete absence of sexual feeling; and the assumption of some sexual feeling led, almost necessarily, to the assumed existence of some sexual organ, and the uterus and vagina being absent there were only ovaries and Fallopian tubes to fall back upon. I concluded, then, that the ovaries were probably present.

'In the spring of the present year she came to me again, not a bit better for any medicinal treatment that she had ever had, and I suggested the propriety of an exploratory incision, in order that the ovaries might be removed if my expectations as to their presence were fulfilled. She was at last admitted into the Hospital for Women, and on June 23rd the ovaries and portions of tubes, as you see them, were re-

moved. The result fully justified my expectations, as the patient experienced almost immediate relief from her symptoms, and they have not returned up to the present.'

Dr. AVELING said he had seen five cases in which there was neither vagina nor uterus, although the ovaries were present. In one case the patient suffered every month from headache and general discomfort. She declined to have the ovaries removed. The existence or non-existence of the ovaries, he believed, might always be determined by the presence or absence of pubic hair.

In reply Mr. BURTON said that the pubic hair of the patient was normal; the breasts were well developed; the labia majora, and also minora, fairly developed—rather under if anything. The urethra was so large that the finger could easily be passed into the bladder, and thus the whole of the parts lying between rectum and bladder could be explored by means of a finger in each cavity. The only trace of uterus to be felt in the way was two small bodies, about the size and shape of split almonds, diverging from each other upwards (ununited Müller's ducts?). At the operation these bodies were both covered above by a reduplication of peritoneum and the uterine ligaments were continuous with this.

Dr. CHALMERS showed a specimen of an ovum in ovo, the subject having been lately ventilated in the medical journals. This was an example of a perfect hen's egg, of almost natural size, enclosed within a perfect egg of abnormally large size. He mentioned the two explanations that had been given of this phenomenon—one that, owing to reversed peristaltic action, the egg, after it had received its shell in the oviduct, travelled back, got enveloped in another supply of albumen and yelk, and then passing on again to the oviduct received its second cretaceous covering; the other view being that the second egg overtakes the first in the oviduct after it has become covered with shell, surrounds it, and in turn gets its shell before being extruded. He also showed the uterus of a patient who died, six weeks after delivery, of pyæmia. Before delivery she suffered intensely

from inflammation of the veins of the leg. After delivery very little œdema showed itself, but she had frequent rigors, and after death the common iliac vein was found full of pus. The veins about the uterus were extensively filled with blood clot, the same being seen in the substance of the womb. There were also two small collections of pus on the posterior aspect of the uterus near its margins. The body of the organ showed little sign of inflammatory action.

Dr. IMLACH showed the following specimens :—

1. Papillomatous tumour of the left Fallopian tube, removed from a patient, aged 42, in October. The chief symptom was dysuria, which had lasted four and a half years. Her last child was born fifteen months previously. After the abdominal incision was made, the tumour was found closely attached to the bladder, and it seemed like cancer of the viscus, but it was peeled off without injury. It was the size of a small orange and contained thick mucus. On microscopic examination by Mr. George Hamilton it was pronounced to be distinctly carcinomatous. There appeared to have been no extension of the disease, and the patient had gone home to Wales cured of her dysuria and apparently well.

2. Caries of the coccyx, removed on July 11 from a young woman aged 24, who had a child eight months old. Painful sitting was the chief symptom, and the feeling of bared and rough ends of bone rubbing together constituted the diagnosis. There was no ulceration of skin, thickening of tissues, or abscess. Excision was an easy matter; the wound healed rapidly and the patient was entirely relieved of her pain. He thought that excision of the coccyx or even lateral incisions for coccygodynia, where no positive disease could be discovered, was an error in practice. Coccygodynia was symptomatic and not an entity; its proper place was with other and often more important symptoms, and it ought not to be isolated in a separate chapter of a book.

Mr. LAWSON TAIT showed the following specimens :—

Four examples of ruptured Fallopian pregnancy about the end of the third month. In all the cases extensive hæmor-

rhage had taken place into the peritoneum, and the patients were in a condition of extreme danger. They were treated by abdominal section, and made easy and rapid recoveries. These constitute a complete series of twenty cases, every one of which has recovered except the first:—

E. D., aged 30; E. R., aged 25; E. S., aged 31; H. P., aged 42.

C. W., aged 34, ovarian cystomata, right side, twisted pedicle, tumour gangrenous, effusion of blood into it. Good recovery. (June 22, 1885.)

A. E., aged 33, hæmatosalpinx on the left side and hydrosalpinx upon the right. Patient recovered. (Aug. 22, 1885.)

L. M., aged 31, double pyosalpinx. Recovery. (Aug. 29, 1885.)

H. S., aged 39, double hydrosalpinx. Recovery. (Sept. 11, 1885.)

M. S., aged 38, cystoma, left ovary, dermoid. Recovery. (Sept. 25, 1885.)

E. P., aged 40, double hydrosalpinx. Recovery. (Oct. 15, 1885.)

M. W., aged 39, double hydrosalpinx. Recovery. (Oct. 17, 1885.)

M. H., aged 40, myoma, hysterectomy. This patient was sent to me from Oxfordshire by Mr. Cheatle, of Burford, on account of a large uterine tumour which fitted into the pelvis like a ball-valve, causing considerable distress. I was under the impression that removal of the appendages might cure her, but on opening the abdomen I could find only one set of appendages, the right, which lay with the ovary in front of the tumour and extended over to the left side, the fimbriated extremity being attached on the right where the left tube ought to have risen, and no left tube could be found. The appearance of the tumour, too, was suggestive of its being rather a sarcoma than a myoma, and therefore I performed hysterectomy, and my original observation was confirmed that there was only one set of appendages, arranged as described. The patient recovered. (Oct. 21.)

M. H., aged 37, dermoid cystoma, right ovary. Recovery. (Oct. 23, 1885.)

M. O., aged 39. The right ovary and tube were found to be intimately associated with—in fact to be spread over—a cocked-hat-shaped pediculated piece of the tumour, necessitating removal of the same. The appendages on left side were normally related and easily removed. The patient is doing well. (Oct. 26.)

Hernia of the Ovary. By HEYWOOD SMITH, M.A., M.D., Senior Physician to the Hospital for Women and to the British Lying-in Hospital.

CASES of hernia of the ovary are of sufficient rarity to render their narration always a matter of interest, and for the sake of throwing light upon their origin and indirectly on the function of menstruation, as well as from their importance to the patient, should be recorded with sufficient attention to accuracy and fulness.

I will in the present paper first of all give details of a case that came under my own observation, and then make some remarks upon the whole subject, referring as far as I am able to the observations and writings of others.

M. A., aged 23, single, a domestic servant, was admitted into the Hospital for Women, January 31, 1885. Her parents died when she was an infant—causes not ascertained. Her mother was married twice, and had two daughters by her first husband, one of whom is living, and, as far as is known, is well. No record of the second girl. There were five children of the second marriage, including the patient, who is the youngest. Three of these were boys, two of whom are living and well. One is a father. The third boy died, when twenty-three, of fever in India. Patient's sister is twenty-five years of age, single, healthy in every way. Occupation, a nurse.

Up to her twentieth year patient says she had excellent

health. She remarked she had leucorrhœa, but took no steps to ascertain the cause. Her present illness she dates from her twentieth year. While doing her housework she was suddenly taken with violent pains in the lower part of her stomach. The doctor who attended her sent her to Maidstone Cottage Hospital under the care of Dr. Montgomery for six weeks. It was at this time that she first noticed a lump in her right groin. She was then sent to the Middlesex Hospital under Mr. Hulke, was an in-patient for about nine months and was operated upon in the right groin. Through the kindness of Mr. Hulke I am enabled to give the following *précis* of the case taken from his hospital note-book, volume 127.

'Double ovarian rupture, bicornute uterus, imperforate vagina. M. A., aged 20, admitted into Regent ward, January 24, 1881. *History.*—Six weeks ago, whilst carrying a heavy bedstead, a sense of something having given way in her left groin, and a few days later a similar sensation in the right groin. This was so severe as to make her go to bed. The medical man who saw her diagnosed hernia, and sent her into Middlesex Hospital under my care. Present state:—In the left groin a movable knot of the size of a small walnut, but longer and more oval in form; of firm consistency, reducible into the canal, but not so clearly through the internal abdominal ring into the belly. In the right groin a smaller knot incompletely reducible through the external abdominal ring. Above it when she coughs a larger mass protrudes into the canal through the internal abdominal ring.

'*Diagnosis.*—Double ovarian rupture. After reduction a truss was easily borne on the left side, but could not be worn on the right. This rupture was therefore laid open and the ovary with the Fallopian tube were removed. The latter tube was short, and at the upper end of the inguinal canal depended a fleshy body which I considered the right horn of the bicornute uterus. Wishing to verify this, I told my assistant to place his finger on the surface of the uterus in the

vagina, whilst I pulled on the fleshy body in the groin. It was then first learned that the vagina was imperforate. The inguinal portion of the uterus was invested by peritoneum *which passed directly into that of the hernial sac,* and thus fixed the organ *in situ.* Examination through the rectum revealed at full depth of finger a small body of the size of a little chestnut, which I considered the imperfectly developed lower part of the uterus. The depth of this and its evident imperfectness were, I thought, too unfavourable to warrant me in advising any operation for opening up the vaginal tube. The woman spoke of occasional uneasiness in the belly, and a blood tinge in her water, but careful inquiry by the ward sister made it evident that she had not menstruated. This point was the subject of careful inquiry, because not long previously another patient in the same ward had been operated on for imperforate vagina, who had menstruated through the urethra. The excised ovary contained two corpora lutea, and I had thought that if any symptoms indicating nisus supervened the best course would be excision of the left ovary.' Mr. Hulke here draws a rough sketch of the parts concerned in the operation.

She was next under treatment at Ashbourne. Pains in the groin have become so bad that she cannot do any work. She came to the Hospital for Women as an out-patient under the care of Dr. Bedford Fenwick, January 13, 1885, when he sent her into the hospital under my care.

The account she gave of her case when in Middlesex Hospital was that she was under chloroform for six hours, was told the operation was severe, and that the wound healed up very slowly. The lumps in the groin are large and painful, and both the size and pain increased every three weeks for about three days; the pain being of a burning, cutting, darting character, through to the external parts. Her general health is good. I saw her February 3. Aspect fairly natural, lips rather red, tongue dirty; abdomen soft and resonant; breasts full but rather flabby; the areolæ very slightly stained and dry; papillæ just visible. Just above

the fold of the groin on both sides, rather nearer to the pubes than half way, are two bodies very tender and sore, feeling as an ovary would do. Mons veneris and vulva natural; vagina only about three-quarters of an inch long; no uterus felt; the fingers can be made to touch from the rectum to the abdomen. Patient passed through a menstrual molimen when in the hospital, during which time the groins were swollen and excessively tender. This passed off in three or four days, but a rather lengthy examination set up a considerable amount of pain, especially in the left inguinal region. A gurgling sensation was felt in the left tumour, after which it became smaller. This, she says, has frequently occurred before, and has always given rise to similar pain. Pain complained of was of a shooting character down the thigh from the left groin, with inability to extend the hip joint without arching the lower part of the spine.

February 16.—Operation under carbolic spray. An incision was made, two inches long, half an inch above Poupart's ligament and parallel to it, and the tissues carefully dissected down till the sac of the peritoneum was opened, when a hardish red substance came into view, which proved to be the uterus. It and the ovary, together with the oviduct, were then drawn out of the wound. The finger was then passed into the abdomen and across to the right side where the other hernia was, and nothing was felt. The pedicle, including the broad ligament and rudimentary uterus, was then tied with soft silk in three sections, and again one ligature all round, and the whole cut away. The stump filled up the hole in the cavity with the exception of a very small corner not larger than a No. 12 catheter. The flap was fastened over on to the stump with two fine silk sutures. The wound was closed at its two ends with four silkworm sutures, and the ligatures with the pedicle left hanging out of the wound, which was dressed with lint bags containing disinfecting powder, gauze pads, and a bandage.

The parts removed consisted of the uterus, which was about the size of a large marble, the rudimentary cervix, of

the size of No. 7 catheter, being cut through just close to its extremity.

The ovary was about two inches long by one inch broad, and the oviduct was of full size.

After the operation the temperature rose to 100°, and the next day to 101°. It then came down in the next three days by varying steps to 99°. Then for three days remained at 100°, when it rose on the 22nd to 101°. On the morning of the 23rd it sank to 99°, rising in the evening to 102°, after a rigor at 4.45 P.M. It then fell the next day to 99·6°, when it gradually came down, and from February 28 remained fairly normal.

During the attack of peritonitis the abdomen was considerably distended. She had some troublesome vomiting, and considerable tenderness. The dressings were removed on the 18th and the stitches taken out. On the 19th the wound was looking free from inflammatory signs, but on the sutures being removed and the wound opened a little, purulent fluid was evacuated. The abdomen remained more or less distended until about the 24th. The wound continued to discharge freely until the ligatures came away on the 29th, after which recovery went on uninterruptedly. On March 13 a careful examination was made, but no trace of uterus or any hard growth was detected. She left the hospital on March 16, and went to a Convalescent Home at Littlehampton. I saw her again on March 23. Since the operation there has been no attempt at any menstrual nisus, but there has been some pain across the abdomen, and in the back. Her appearance is bright, natural and feminine, and I have reason for believing that her sexual feelings have not been altered by the operation. On March 29 I made a very careful examination, but failed to detect any indication of a uterus or part of one. In the left groin—that is, the side where I operated—on the patient coughing there is a slight hernia of the intestines commencing just above the cicatrix. This weakness is remarkable considering the amount of inflammation which succeeded the operation, which one would have supposed would have sufficiently blocked up the inguinal

canal. On the right side the hernia is well marked, about the size of a pigeon's egg, and considerably tender. An attempt to reduce this hernia was not wholly successful, and finding she could not bear the flat pad of the ordinary truss, at Mr. Reeves' suggestion I had a cup-shaped pad made to cover the hernia on that side.

I saw the patient about a fortnight ago. She said she flushes daily, especially at the periods. She has lost the dysmenorrheal pain; but she still suffers because of the hernia on the right side.

The best account of hernia of the ovary that I have been able to consult is a paper on 'Hernia of the Ovary, and Observations on the Physiological Relation of the Ovary, with a Relation of Cases,' by Dr. Robert Barnes, in the American 'Journal of Obstetrics' for June 1883.

He there details about twenty-six cases, mentioning thirty-eight more as reported by Englisch. In these cases of hernia of the ovary it is a remarkable feature that, in a fair proportion, there was absence of the uterus, and either absence of or quite undeveloped vaginæ. The hernia did not seem to have affected the development of the external parts nor the breasts. In most of the cases application for relief was sought because of pain that accompanied the menstrual nisus.

Dr. Barnes' observation that the frequency of the coincidence of hernia of the ovary with an anomaly of the organs of generation is remarkable, is fully borne out by the case that I have just narrated. In this case also the late appearance of the menstrual molimen is to be noticed, the patient not suffering from the supervention of this function until the age of twenty; and then it is to be noticed that it was while doing her household work that she was suddenly seized with violent pain. This probably was the first step in the production of the hernia, and it becomes an interesting question as to how far pain would have been a characteristic symptom if the condition had obtained, with such a rudimentary uterus, of the ovaries remaining in the abdomen; but it seems probable that, from the observation Mr. Hulke makes as to the

reflexion of the peritoneum and from the intimate relation of the fold of the peritoneum on the left side observed during my operation, that the commencement of the hernia was really congenital, that the ovaries were held or retained in part of the inguinal canal, and that the oncoming of the menstrual function was really late. This lateness of the development of the menstrual function also gives rise to another question which needs further investigation, as to how far the existence of a normal uterus is necessary for the perfect and normal development of the function of menstruation. We see by the existence of corpora lutea in the ovaries that ovulation took place naturally, but the rupture of the ovisac does not seem to have been attended at any time with the production of peritonitis or hæmatocele.

With regard to the operation on the right side as carried out by Mr. Hulke, the fleshy knot which he drew forward and took for the right cornu of the uterus was more than probable the uterus itself. On speaking to him on the subject, he however still maintained that it was the right cornu of the uterus, although, when I operated on the left side, the uterus coming at once into view induces me to think that my view of the case is the correct one, inasmuch as, if the part that I removed was the left cornu, it would necessitate the existence of a wide divarication of two cornua, and therefore the existence of a larger compound uterus than I think could possibly have existed without detection by examination, and, as I have stated, very careful examination, both at the time of the operation and subsequently, has failed to reveal the existence of any hard body such as uterine tissues would give.

These cases are extremely interesting, and I would venture to suggest that in any investigation into the physiology of menstruation, careful study of the relative size, condition, and vascularity of the ovaries, and more or less rudimentary uteri, in these cases be carefully made, in order if possible to throw some light upon the relative parts played by each organ in the function of menstruation.

Hernia of the Ovary, by LAWSON TAIT, F.R.C.S.

M. A. S., aged 26, under the care of Dr. Wilkes, of Salisbury. At six years of age noticed to have a rupture, for which she was recommended a truss. Wore it for four years. Dr. Wilkes removed it then and advised that it should not be applied. Her menstruation was regular, but for the last three years very painful. September 14 I removed the tumour; it contained a pint and a half of fluid and several cysts. The walls of the cysts were clearly those of an ovarian tumour, and the end of the Fallopian tube protruded through the ring at the base of the tumour on its under aspect, and was removed along with it. The cavity which had been occupied by the tumour was drawn together by deep continuous sutures, enclosing a piece of drainage tube. It healed without any suppuration, and the patient went home on the fifteenth day after the operation.

Dr. BARNES said that in his memoir, and elsewhere, it was established that hernia of the ovary was frequently associated with abnormalities of the genital organs, and that the herniated ovary was not uncommonly diseased.

The PRESIDENT had seen a case of hernia of the ovary in which the displaced organ had swelled and become tender at each monthly period.

Dr. FANCOURT BARNES had observed the same phenomenon just mentioned by Dr. Meadows. He saw the patient in St. George's Hospital. At each menstrual epoch the ovary swelled up and became unusually sensitive to the touch. Coincidently with this tumefaction the pulse, taken by the sphygmograph, gave evidence of high tension, which subsided *pari passu* with the disappearance of the menses and the swelling of the ovary.

The Society then adjourned.

REVIEW.

The Cessation of Respiration under Chloroform, and its Restoration by a New Method. By R. MILNE MURRAY, M.A., M.B., M.R.C.P.E. (Edinburgh: Oliver and Boyd.)

THIS is a short but interesting monograph on the 'behaviour of the respiratory mechanism under the influence of chloroform,' a subject which has as yet attracted but little notice as compared with that accorded to the action of this agent on the heart and circulation.

The author gives an account of a series of experiments made by him, by means of the further administration of the vapour of chloroform to rabbits already anæsthetised, the vapour being (α) in a concentrated form, and (β) diluted with air, each being given first continuously and then intermittently; and he finds that the respiratory movements, both as to volume and rate, vary considerably under these different conditions. A number of tracings illustrative of these variations are given.

The practical conclusions derivable from these experiments would appear to be:—

1. That the lungs are affected before the heart, the latter continuing to beat after the cessation of respiration.

2. That the safest method of administering chloroform is the continued use of the dilute vapour.

3. That the most dangerous method is the intermittent administration of the concentrated vapour. Under this method sudden and permanent cessation of respiration is apt to occur; and further, the air-current may abruptly cease while thoracic movements continue.

4. That once anæsthesia is produced, further acceleration of respiratory movements should be the signal for the instant removal of the vapour, as when once this stage is passed a fatal issue is unavoidable.

The paper closes with some useful hints on the 'timeous' treatment of respiratory cessation. The author considers that the presence of the chloroform vapour in the pulmonary air cells (and its consequent continued absorption) is the chief factor in the occasional failure of artificial respiration as usually practised. He therefore advises 'perflation,' by which term he means the removal of the chloroform-saturated air by suction combined with gentle pressure of the thoracic parietes, the chest walls recoiling by their own elasticity and so refilling the lungs with pure air.

Accurate investigation of the action of chloroform on the respiration has thus far been sadly wanted, and this paper is the fullest contribution to the subject that has yet been made, and is well worth careful perusal by all interested in the action or administration of anæsthetics.

JAMES HARPER, M.D.

SUMMARY OF GYNÆCOLOGY, INCLUDING OBSTETRICS.

A New View of Menstruation.—The menstrual process in the uterus may be considered as consisting of three phases passing one into the other.

1. Hyperplasia of the mucous membrane.
2. Hæmorrhage with disintegration of its superficial layer, and—
3. Restitution to the normal state.

The whole process lasts about twenty days, hyperplasia occupying ten of these, hæmorrhage and restitution four to five days each.

The phenomena observed in the other organs of generation and in the general system in connection with menstruation occur during the stage of hæmorrhage, towards the close of which those symptoms appear which indicate the rupture of a Graafian follicle; and this rupture or approaching rupture is generally considered to be the cause of the hæmorrhage, But while there is abundant evidence of the existence of a causal relation between ovulation and menstrual hæmorrhage, the assumption that this causal relation is a direct one rests only on their coincidence in time; and it may be that not only is hæmorrhage not a necessary physiological result, but that it is never the immediate consequence of ovulation, that the ovulation and hæmorrhage occurring at any one menstrual period are separate processes, and that between the former as cause and the latter as effect a third factor intervenes, the unfertilised ovum.

A Graafian follicle ruptures and liberates a mature ovum, which, having passed through the Fallopian tube into the uterus, embeds itself in the first suitable fold of the mucous membrane, as a rule near the uterine mouth of the tube. As the immediate consequence of its presence, hyperplasia is set up, and forms the menstrual decidua. If the ovum is here impregnated, the menstrual decidua develops into the decidua of pregnancy; but if within a certain time, the limit of its vitality, the ovum is not fertilised, it perishes and by its death causes the active hyperæmia, the disintegration of the menstrual decidua, and the hæmorrhage from the mucous membrane. The hyperæmia reacts upon the ovary, and causes the rupture of a Graafian follicle matured since the dead ovum was set free.

It has been held that impregnation takes place either (1) at the ovary, or (2) in the outer part of the tube. The only fact supporting the former view is the occurrence of extra-abdominal pregnancy, and the rule has been deduced from the exception; if the place of development is to decide the place where impregnation occurs, the probabilities are 10,000 to 1 in favour of the uterus. That fertilisation takes place in the outer part of the tube is a view depending on observations on rabbits, in which the ovum is invested with an albuminous coat, impenetrable by spermatozoa, immediately after entering the abdominal mouth of the tube, and it is by no means ascertained that this takes place in the human being.

That the ovum, after it is embedded in the uterine mucous membrane, retains a certain capability of life, varying within narrow limits in each case, is probable; for it has been proved that a woman may conceive in consequence of a single coitus on any day between two menstrual periods, and, therefore, that of the two factors, spermatozoon and ovum, one must wait for the other and retain its capability of action during the delay. It seems more probable that the ovum should do this than the spermatozoon. The ovum is the larger of the two; it is probably, before fertilisation, at least as strong constitution-

ally as the spermatozoon after immission into the female genital canal and while it is debarred from its function. The ovum is near its native place, and a stationary position is absolutely necessary for its future development: whereas the spermatozoon is on strange ground; it is, while alive, incapable of rest; and its existence, except in the womb or oviducts, is known to be very short. And the ovum, once set free, must pass on to the womb, fertilised or not. The conditions of its advance through the Fallopian tubes are not such that a distinction can possibly be made between the two cases. It is, therefore, in the uterus that the ovum must wait for the spermatozoon.

It is true that in animals the semen penetrates into the tubes perhaps further; but though spermatozoa are found in the human womb, they have never been discovered in the tubes or at the ovaries, where they certainly must exist during the entire sexual life of every cohabiting woman if fertilisation always happened there, and if, therefore, they normally penetrated so far at every coitus. It is also true that, except in one case, no unfertilised ovum has ever been found in the uterus; but it is much more difficult to detect an ovum embedded in the uterine mucous membrane than to find a spermatozoon. It may seem that if this theory of Löwenthal's was correct, conception should always follow coitus, and pregnancies be much more frequent; but he points out that it is not coitus, but entrance of the spermatozoon into the womb, that leads to impregnation, and this does not always take place. Many men are sterile who are not impotent, and sterility may be due to independent causes, to disease or idiosyncrasy, or may be intentional.

The duration of the vitality of the unimpregnated ovum is the measure of the intermenstrual period; when conception does not take place, the ovum perishes, the menstrual decidua disintegrate with loss of blood. The periodicity of the menstrual discharge depends on the extrafollicular life-period of the ovum, not on the length of interfollicular maturation. The clinical fact that the menstrual periods are

shortened at the commencement of debilitating illnesses supports this view. The vitality of the ovum produced by the weakened organism is less enduring. Its premature death causes an earlier disintegration of the menstrual decidua, an earlier return of the hæmorrhage.

Follicular dehiscence may occur independently of menstrual periods, but the great congestion accompanying the menstrual process during the latter part of the hyperplasia and during the disintegration of the decidua stimulates the maturation and hastens on the escape of an ovum, and ovulation, in itself a periodic, recurs regularly, as depending on the extrafollicular life-period of the unfertilised ovum.

If no ovum is liberated, or if the vitality of one set free is imperfect, it either does not embed itself in the uterine mucous membrane, or, if it does so, dies after a few days or hours. During this short existence impregnation may possibly take place, but if not, the decidua is either not formed at all, or so imperfectly developed that on its disintegration no hæmorrhage takes place; there is in fact amenorrhœa.

Clinically it would follow that, as menstrual hæmorrhage is not a physiological process, it should neither be induced when it is absent, nor allowed to continue in persons who are anæmic or debilitated, nor if it is accompanied by nervous or other complications of a serious nature. Cases are reported which have been cured or much benefited by the suppression of the menstrual discharge by means of complete rest in bed and hot-water injections, which add much interest to Löwenthal's papers on this subject in 'Archiv für Gynäk.' Bd. xxiv. Hft. 2, and Bd. xxvi. Hft. 1.

JAMESON J. MACAN, M.A., M.R.C.S.

Porro-Operation in Missed Labour from Multiple Myomata.—The case was a primipara. The parts of the child were so easily felt, that abdominal pregnancy might have been suspected but for the existence of a myoma the

size of a hen's egg on the left upper side of the uterus, proving the sac to be a muscular one. After examination under chloroform, the case was considered to be most probably one of pregnancy in one horn of a two-horned uterus. Laparotomy was performed by Herr Sänger; the uterus was found to be single, the seat of multiple myomata, and as decomposition had commenced a modification of the Porro-operation was carried out: the fœtus was greatly macerated and the waters offensive. Death after two days and a half from acute sepsis. Of five myomata, two the size of a closed fist were soft and in a state of complete fatty degeneration. A rare retrograde metamorphosis, of which Gusserow mentions only two cases.

The missed labour was caused by the myomata. Strong observed a case in which, owing to a subserous myoma the size of a child's head, pregnancy was lengthened twenty-six days, and the labour was so protracted that turning and separation of the placenta were necessary. On examination under chloroform, the index finger was arrested as soon as it was introduced into the cervix, and could feel the fœtal parts to the right as through a thin partition septum: the finger was taken to be in the left horn of a bicorned uterus, and the fœtus in the right. This deception was caused by a myoma stopping the index, being supposed to be the fundus of an empty half of the uterus.—'Gesellschaft für Geburtshilfe zu Leipzig,' May 19, 1884.

Oophorectomy.—Between June 1882 and March 1885, Howitz of Copenhagen performed this operation in 62 cases, only one of which ended fatally: 56 were cases of true ovarian tumours; 55 cystic; 2 of the cases were uterine fibroids; in 3 the ovaries were morbidly altered, but not of excessive size, while one case was tubal pregnancy in close relation with the ovary. Howitz has himself fitted up a house for these cases outside the town of Copenhagen: he uses the most stringent antiseptic precautions, and to this he attributes his great success. Besides the administrator of ether he has only one assistant.

There was generally a rise of temperature, attaining a

maximum within thirty-six hours, followed by a rapid fall. with very often an increased secretion of urine, and a sanious discharge from the genitals. This rise in temperature he attributes to the antiseptics, especially to the carbolic acid, to the compression of the abdomen, and perhaps to the ether.

The single death, from sepsis on the seventh day after a severe ovariotomy complicated by a rupture in one of the broad ligaments during the extraction, he attributes to the presence of a physician who had operated the previous night on a case of croup.—'Howitz's Gynækol. og obstetr. Meddelel,' Bd. v. Hft. 3, pp. 233–248.

JAMESON J. MACAN, M.A., M.R.C.S.

OBSTETRICAL SOCIETY OF LONDON.

WEDNESDAY, MAY 6th, 1885.

On the Ulceration of Lupus of the Female Generative Organs, including Perforations, Pits, and Excavations.—Dr. Matthews Duncan read a paper on this subject. He said that ulceration was not an essential part of lupus. Some ulcerations were to be regarded rather as excoriations than as lupus-ulcers. Generally, ulceration was accompanied by hypertrophy. The hypertrophied parts were not specially liable to ulceration. The ulceration might affect the hip or thigh, or any part of the genital organs, external or internal, also the bladder and rectum; the ulceration was generally not sensitive. There might be one or many ulcers. Lupus minimus was characterised by small ulcerations. The skin, mucous membrane, and subcutaneous cellular tissue were the parts chiefly affected; but any structure (except bone) might be destroyed. Sometimes the skin was chiefly affected; sometimes the subcutaneous cellular tissue. The ulceration sometimes produced pit-like cavities, sometimes producing great excavations, sometimes perforating, producing fenestræ or fistulæ; the peritoneum might be perforated. The ulceration was not accompanied by sloughing. The ulcers might

heal in whole or in part. Ulcers, the result of wounds of hypertrophied parts, healed favourably. A specimen from the London Hospital (lent by Dr. Herman) of dilated uterine cavity, with perforating ulceration, was shown.

Dr. Champneys asked Dr. Duncan (1) on what grounds these very different affections were included under the same name; (2) why they were called lupus when microscopists pronounced the appearances to be unlike those of lupus; (3) what these diseases were called before they received the name of lupus.—Dr. Matthews Duncan replied that he used the term lupus because others did so. West, in his 'Diseases of Women,' used this term. Esthiomene was an awkward word. Lupus expressed the great eroding character of the disease; it included ulcerations, inflammations, hypertrophies, variously combined, and which were not cancerous, not epitheliomatous, not syphilitic. It might turn out that several diseases were included in this comprehensive term. At present they were combined for description on account of their apparent similarity. They were far from being as uncommon as was supposed.

A case of Uterine Fibroid complicating Labour, and treated by Enucleation.—Mr. William H. Day (Norwich) described this case. The tumour itself presented, and above the tumour a breech. The size of the tumour and its immobility precluded the possibility of delivery while it was *in situ*. After separating its connections to a great extent, and thereby attaining greater mobility of the tumour, delivery was effected by the feet, the remaining attachments were severed, and the tumour removed. It weighed 3¼ pounds, was a soft fibroid, and would nearly have filled an ordinary tall hat. A successful case of enucleation of a large fibroid immediately after parturition induced Mr. Day to adopt this treatment. The patient lived for twenty-eight hours after delivery. The child survived.—Dr. Braxton Hicks reminded the Society of a case which he had read before it some years ago, in which he divided the capsule by a bistoury vertically, and enucleated the tumour from its capsule with complete ease and success.

This he thought best in the case of sessile or embedded fibroids. He called attention to the work of Dr. Chahbazian on the fibrous tumours of the neck of the womb in pregnancy and labour, to a paper by Dr. Mundé of New York, and to a case of Dr. Fry. He thought that, when delivery was urgent, the general opinion was in favour of enucleating the sessile forms from their capsule, which, in all the cases reported, was not a difficult operation.

WEDNESDAY, JUNE 3rd, 1885.

On Serous Perimetritis.—Dr. John Williams gave an account of three well-marked cases, and a description of the appearances after death in one. Dr. Williams concluded that the disease was due to extension of inflammation from the uterus, that it commenced in the peritoneum in the neighbourhood of the ovaries, and extended along the brim of the pelvis, matting the intestines to the fundus of the uterus, and converting the pelvic cavity into a closed sac. Into that sac serum was effused, which raised the uterus upwards and forwards, and depressed the posterior wall of the vagina, so as to protrude through the vulva in some cases. The effused serum became coagulated at the upper part, where adhesive peritonitis was present, and formed in some cases a considerable mass. This mass fixed the uterus, and was the hard swelling felt after tapping.—Mr. Knowsley Thornton had seen two cases of the disease, one of which had recovered after tapping and drainage, and the other (presumed to be a similar case) had died without local treatment, without a necropsy. He urged that the connection of the onset of these cases with delivery, abortion, and sudden checking of the menses, pointed to escape of fluid from the Fallopian tube. The fluid, however, was not septic, as would be expected; indeed, if it became septic (as after tapping), the case almost always ended fatally, in the absence of a free opening and washing out the cavity. The disease was practically a separate disease from ordinary pelvic peritonitis

and cellulitis, with which all were familiar. The material causing serous perimetritis was evidently very irritating, as shown by the dense adhesion. He inquired whether the semi-solid material described by Dr. Williams was the result of irritation or of secretion under pressure. The pressure was indicated by the great pain accompanying the disease. As to treatment, aspiration was inferior to free opening by a trocar, and maintenance of the opening so formed, with washing out of the cavity.—Dr. W. Griffith thought that the great difference of opinion arose from the want of a precise definition of serous perimetritis. Some, who thought the disease rare, limited the term serous perimetritis to cases with large effusion. He believed serous perimetritis to be the commonest form of perimetritis, by the analogy of pleurisy with effusion of serum and that of other inflammations of serous membranes, and by the displacement of the uterus and its rapid subsequent retreat. The specimen which he showed illustrated the occasional sudden disappearance of the signs; the serum escaping by rectum, vagina, and bladder, and not showing its presence as pus would.—Dr. Galabin had met with a fair number of cases in which encysted serous perimetritis had been diagnosed, and the diagnosis confirmed by the gradual disappearance of the swelling and the recovery of the patient. In one case, the resemblance to an ovarian cyst had been very close, a fluctuating swelling in Douglas's pouch being felt as a tumour reaching above the navel. A diagnosis of serous perimetritis was made because of the acute inflammatory symptoms with which the affection began. It eventually disappeared completely. He had only once tapped a serous perimetritis, and that in consequence of an error in diagnosis. Tapping was generally unadvisable. His case illustrated the fact that these cases might sometimes have the rigors and high temperature usually thought to indicate pus. It was aspirated, and clear serum drawn off with antiseptic precautions. The patient became worse, showing septic symptoms; the swelling filled again; a free incision was made, a large drainage-tube kept in, and the

cavity washed out with a weak solution of iodine. The patient recovered after a serious illness.

In reply, Dr. Williams said that his first case was improved by tapping; that she died from severe diarrhœa, for which there was ample cause other than sepsis; and the contents of the sac were quite sweet and antiseptic after death. The little serum at the bottom of the sac was clear and sweet. As to the rarity of the disease, Dr. Williams was surprised to hear from several speakers that they had seen several such cases. There were only about half a dozen cases on record, and the majority of the systematic writers on the diseases of women said little or nothing about it.

Specimen of the Pseudo-osteomalacic Pelvis of Naegelé.—Dr. Walter Griffith showed a specimen, which was bought in Paris by Professor Humphry, of Cambridge, and lent by him. It was obviously rachitic, but had some of the characteristic deformities of mollities, including a much-curved instead of a flat sacrum, much-curved iliac fossæ, and a triangular in place of the usual flat brim; the posterior parts of the ilia were moulded round the sacrum. The os pubis, however, was not peaked, as was the case in other specimens of this type. It was suggested that the cause of this unusual deformity was a severe form of rickets occurring later in childhood than usual. References were given to other recorded specimens, and to papers on the subject by Smellie, Dr. John Burns of Glasgow, Naegelé, Michaelis, Litzmann, and Spiegelberg. Photographs and detailed measurements were also given.

J. MANSELL-MOULLIN, M.D.

WEDNESDAY, JULY 1st, 1885.

Notes of a visit to some of the Lying-in-Hospitals in the North of Europe, and particularly on the Advantages of the Antiseptic System in Obstetric Practice.—These notes were read by Dr. Priestley. The hospitals visited were those at Copenhagen, Helsingfors, and St. Petersburg. At Copen-

hagen the new system began in 1870. In the Maternity Hospital, in the fifteen years from 1850 to 1864, the mortality was 1 in 24; between 1822 and 1843, it had been 1 in 19—that is, only slightly lower than the mortality in the Nightingale Charity of King's College Hospital, which compelled the author to close the ward. From 1865 to 1874 the mortality from puerperal fever was 1 in 51; from 1870 to 1874 it was 1 in 87, the improvement coinciding with increasing strictness in antiseptic precautions. The hospital was constructed in the most elaborate and expensive way to secure hygienic perfection, including ventilation, isolation of each part of the building (if desirable), and even a separate room for each patient. Moreover, the rooms were only used alternately, which was equivalent to halving the number of beds. The attendants were under strict rules of periodical purification, and were not allowed to pass directly from the convalescent to the lying-in wards. If a patient had been ill, the nurse was fumigated with sulphurous acid gas by an elaborate process. The same was used for disinfection of the rooms. The personal precautions included careful antiseptic hand-washing, soaking of catheters, &c. No sponges were used. The vagina was injected twice a day with carbolic acid lotion. The beds were of canvas, filled with chopped straw, which was destroyed after use. Each bed had its own basins, syringes, catheters, &c. The placentæ and dressings were burnt. On suspicion of infection the patient was carefully isolated. The medical officers were not allowed to attend necropsies. The director lived in the hospital, of which he was absolute master. As in other hospitals, there was an undue proportion of difficult cases and of primiparæ, and the primiparæ had a large share in the mortality. The midwives of Denmark were compelled to use antiseptic precautions, and this had sensibly reduced the mortality. At Helsingfors the hospital was arranged on the pavilion system, one block being devoted to diseases of women, including wards for operations and rooms for out-patients. The wards for lying-in cases contained about 42 beds; the beds were in the middle of the room. The

mattresses were sacks of fresh rye-straw for the non-paying patients, and with horse-hair or bark of the lime tree for paying patients, all being cleaned, baked, and remade for each new patient. Some patients lay on the bare boards of the bottom of the bed, as was usual in Finland. Antiseptics were not as minutely carried out here. Midwives and nurses were made to wash their hands and arms with soap, and afterwards to rub them with hypochlorite of lime, before examinations. Abnormal cases were isolated. The medical officers were forbidden to attend necropsies, or to touch infectious wounds, without taking antiseptic precautions afterwards. Catheters were carbolised, and the wards periodically closed and cleaned. After labour, a single injection of carbolic acid was given, and often when specially indicated. The linen was simply washed; the blankets were fumigated by burning sulphur. Professor Pippingsköld trusted largely to the excellent hygiene of the hospital (built on a rock high above the town), and to the clean habits of the people; but the external genitals were always washed before delivery; otherwise the object was to guard against external morbific influences, more minute care being thought unnecessary under the circumstances. Before the new maternity was opened in 1879, the total mortality averaged 1·83 per cent. From 1872 to 1884 the total mortality was 1 per cent. In the Grand Duchess Catharine Maternity Hospital in St. Petersburg there were arrangements for isolating the various parts. Scrupulous cleanliness, the disinfection of rooms, concrete floors draining into a central gully, and the careful use of antiseptics, were included in the system. In the last three years there had only been one death from puerperal fever, though six had occurred from other causes.

[The mortality in the British Lying-in Hospital has only been 0·6 per cent. since 1880.—ED. *Brit. Gynæc. Jour.*].

OBSTETRICAL SOCIETY OF EDINBURGH.

WEDNESDAY, MARCH 11th, 1885.

DR. ANGUS MACDONALD showed the following specimens:—

Fibroid enucleated from the Posterior Lip of the Cervix.—The patient had not experienced any trouble from it until a few weeks before she applied for admission. The leading symptoms were those of down-bearing and retention of urine. On examination a tumour nearly the size of a child's head was found filling the vagina. The outer surface of the tumour was continuous with the bladder in all directions, except for a small portion anteriorly. Here there was a cavity which just admitted the tip of the finger, and the sound entered two and a half inches into a hard body like the uterus, which projected into the abdomen above the brim. The uterus itself was clearly not fibroid. The tumour was removed first by cutting into it, and breaking it up piece by piece, until the finger could be pushed through the centre to the base of the mass, where it was completely enucleated. The fragments weighed 1 lb. 14 oz. The patient left the hospital a week after the operation, the cavity having disappeared, and the uterus having gone back to its natural size.

Entire Uterus removed by Vaginal Method for Cancer.—The method adopted was first to depress the uterus with volsellæ, free the vagina from the cervix by the knife, and reflect the bladder with the fingers from the part of the cervix up to the reflection of the peritoneum from bladder to uterus. Then the posterior vaginal wall was separated by knife, and Douglas's pouch exposed and then opened. The base of the broad ligament on both sides was then first tied in position with strong silk, and divided until the finger could be easily passed over the top of the left ligament, when the anterior pouch of peritoneum was opened, and the upper part of the left broad ligament was transfixed and tied firmly in two portions, and finally separated from

the uterus. This allowed the uterus to be pulled sideways outside the vulva, and the remaining upper half of the right broad ligament to be transfixed and firmly tied in two portions. All risk of cancerous infection from inversion of the connecting stump upon the peritoneum was thus avoided. The ligatures on the left side inserted into the lower end of the broad ligaments were rubbed off in removing the uterus, and caused slight bleeding, which was readily averted by transfixing the mass and retying. The ligatures were tied together, right and left, in two bundles and drawn out. There was very little bleeding. The opening in the peritoneum was not drawn together, but the vagina was plugged with iodoform wool. The patient did excellently for two days. There was very little shock and no peritonitis. But on the third day—apparently in consequence of some carbolic oil having been put on a small iodoform plug that was used—sepsis set in, and the patient died twenty-four hours afterwards.

Uterine Fibroid removed from the Anterior Wall.—The tumour is remarkable for the way in which it has developed forwards so very markedly—growing at the same time downwards so as to encroach upon the cervix and bladder. The cervix was very short. But as the patient had nearly bled to death at the menstruation immediately preceding the operation, and was, moreover, very anxious to be operated on, I granted her her request. There was some trouble in keeping the wire of the clamp above the edge of the bladder. There was also some trouble in getting the tumour hoisted out of the pelvis, into which it had got wedged. But ultimately a workable pedicle was obtained. The patient has uninterruptedly done well.

Dr. Hewetson's 'Notes on a Case of Face Presentation, with peculiar Attitude of the Fœtus,' was then read by the Secretary.

Dr. Freeland Barbour read a paper on 'Some Practical Points with regard to the Membranes in the Third Stage of Labour.'

WEDNESDAY, MARCH 25th, 1885.

Dr. Foulis showed a 'section of the ovary of a rabbit,' displaying five ripe Graafian follicles with their contained ova. Also a 'section of the wall of a young ovarian cyst.' In this preparation the cylindrical epithelium lining the cyst cavity was beautifully seen. Dr. Foulis pointed out that the cells of epithelial lining of all young ovarian cysts are at first cylindrical or columnar in form, though, as the cyst enlarged, these epithelial cells greatly altered in form. In almost every young ovarian cyst certain of these columnar cells could be seen giving forth, at their free ends, small, almost spherical drops of colloid matter. In the preparation before the Society numerous epithelial cells were seen, from the free ends of which such colourless globules were being shed. These little solid colloid bodies fell into the cavity of the cyst, and rapidly underwent fatty degeneration, and, as Dr. Foulis believes, become ultimately the well-known ovarian granule-cells of Drysdale. Dr. Foulis holds the opinion that the ovarian granule-cell is neither a nucleus nor a cell, but is a little, solid, spherical or oval mass of colloid matter shed from the free ends of the columnar epithelial cells of all young ovarian cysts.

Dr. Angus Macdonald read his paper on 'Ten cases of Laparotomy performed in the Royal Infirmary from May to November 1884.' They included five cases of ovariotomy, one case of removal of a broad ligament cyst, one case of removal of a sero-sanguineous cyst of the peritoneum, possibly mesenteric, and three cases of removal of the uterine appendages.

WEDNESDAY, APRIL 8th, 1885.

Dr. James Ritchie showed a placenta exhibiting circumscribed hæmorrhages of recent and of older date. The patient, æt. 23, pregnant for the second time, miscarried at the seventh month. Five days before the date of miscarriage, after walking about a mile, she was seized with pains, drove

home, and went to bed. The pains subsided for a time, but recurred the following evening, and again two days later. On the fifth day she gave birth to a small poorly nourished child, and with the placenta was expelled some twelve ounces of dark, firm polyhedral clots with rounded margins. The placenta showed two depressions on its surface, which in the recent state were filled with clot, and near the margin there were still *in situ* three oval clots one and a half inch long. Near the centre were two small, rounded, decolorised masses, which might be shelled out. The placenta was in several places fattily degenerated. The interest of the specimen related to the circumscribed hæmorrhages of recent date. The date could be fixed with tolerable certainty, viz. five days before labour set in. They had acted as foreign bodies and excited labour. The decolorised clots indicated smaller hæmorrhages of older date.

Dr. James Carmichael read a paper on infant feeding.

WEDNESDAY, MAY 13th, 1885.

Dr. James Ritchie showed several specimens of milk curd. He had curded milk under various conditions, and had found the results so interesting, and in some cases so unexpected, that he thought the Fellows might like to see the specimens. All the specimens of milk had, after mixture with various substances, been treated in the same way, viz. they were heated to 98°, a small quantity of common salt was added, then essence of rennet, the mixtures were stirred, then left in the water bath at about 98° for half an hour. After some hours the curd was broken down, and when the whey separated it was filtered off. Pure milk showed a very hard curd in large masses. The dilution with water causes the curd to be considerably softer, and specimens diluted with an equal part of water show a softer curd than those which had only a third of water added. The acidulation of the milk and water with 0·02 per cent. of dilute hydrochloric acid causes the curd to be much harder. If, therefore, a child's stomach in

an irritable condition secrete very acid gastric juice, the curd of milk and water will be a hard one. The addition of farinaceous gruels (oatmeal, barley-water, and rice-water), in the proportion of one-third, causes the curd to be in small soft flakes; and it is very noticeable that if such mixtures be acidulated, the curd is not much harder. The effect of boiling the milk is very marked; the curd is in very small, soft flakes, so small that it is difficult to remove the whey. But when boiled milk is acidulated, the curd is much firmer than that produced in acidulated specimens having gruels added. The addition of one-third of lime-water causes the curd to be in small, soft flakes, not so soft, however, as those produced in boiled milk. And it is worthy of note that a very hard curd is produced in milk with one-third of lime-water, if it be rendered faintly acid. The curd of mother's milk is very soft, and in small flakes. The amount of essence of rennet added to the specimens of cow's milk caused them to have an acid reaction to litmus paper, but a larger proportion had to be added to mother's milk before the acid reaction was obtained. These specimens confirmed the results obtained in practice, viz. the measure of advantage gained by dilution of the milk, the great benefit of boiling it, the marked improvement in the quality of the curd if it be kept open by mechanical means, as by the addition of gruels or of lime-water. But they show that this benefit is lost in the case of lime-water mixtures if much acid is present, and that under such conditions a softer curd is obtained by mixture with gruels than by boiling only, or by addition of lime-water only.

Mr. Skene Keith showed a double hæmato-salpinx from a patient aged thirty. There had been profuse uterine hæmorrhage for seven weeks before operation, and for that time she had been unable to get out of bed. Both tubes were greatly distended with blood, and along with the ovaries were closely adherent low down in the pelvis. In addition the pouch of Douglas was filled with old blood clot, which had to be sponged out. The patient made a good recovery.

Dr. Foulis demonstrated a 'mode of readily obtaining the fibrinous deposit in ascitic fluid,' with the view to render certain and easy the diagnosis between ovarian and ascitic fluids. The method consists in suspending a soft cotton thread in a bottle containing the fluid to be examined. In the course of a very short time the precipitate forms in the spaces in the thread in the case of ascitic fluid, and can be readily recognised under the microscope. Dr. Foulis claims that this method of examination is both expeditious and absolutely correct when taken with the microscopic examination of the deposit in the fluid.

Dr. Buist read 'Notes of a Case of Triplets,' a male and two females. The labour was easy, the mother made a good recovery, and all the children survived. The decidua weighed 2 lbs. 13 ozs. There were two distinct placentæ, a larger with two cords, and a smaller with one cord. The larger corresponds to the two females, the smaller to the male child. The two placentæ are connected together by membrane from one to two inches in width. The chorion forms a continuous envelope for the three amniotic sacs. It dips between the sac of the male and the female sacs. Apparently it does not dip between the two female sacs, their amniotic membranes being in close apposition; but on close inspection a small amount of chorion connective tissue can be distinguished. The vessels through both cords to the large placenta intermix freely.

Dr. Angus Macdonald read a 'Report of a Case of Porro-Müller Operation in a Labour obstructed by a Fibro-dermoid Tumour.' The operation, in consequence of the difficulties attending it, lasted one hour and twenty minutes. The child, which was a well-formed, full-timed female, survived. The patient died twelve hours after the operation, probably from the shock of the operation superadded to the exhaustion of a prolonged labour, as no other cause could be found to account for her death.

J. MANSELL-MOULLIN, M.D.

Complete Inversion of the Uterus after Labour; Hysterectomy by means of the Elastic Ligature—Cure—by Dr. Hieguet.—The aim of the author in communicating this note is, as he says, to add a new case to the statistics of the cures of inversion of the uterus by means of amputation effected by the elastic ligature.

Louisa B., aged 24, of very good constitution, though lymphatic, enjoying habitual good health, entered the English hospital at Liège on May 7, 1885. A primipara, she was delivered at time on April 25 of a living child. Ten minutes after the birth of the child the expulsion of the placenta took place, in consequence of a violent effort, but without any traction being exerted on the cord. Immediately after its delivery there was abundant hæmorrhage. Instead of remaining quiet, the patient indulged in immoderate movement; she quitted her bed several times. The result was an inversion of the uterus, which persisted, in spite of the intervention of several surgeons who vainly attempted to reduce it.

On admission to the hospital there was great pallor of the face, the pulse was small and quick, the appetite was *nil*, but there was no fever. A tumour the size of the fist, of roughened surface, and of a reddish-brown colour just appeared at the vulva. Inversion of the uterus was clearly made out. Several ineffectual attempts at reduction were made on May 8, 9, and 10. The first and third were attended with a notable loss of blood; the last especially was followed by great debility. Amputation of the uterus therefore remained as the last resort to save the woman. This was done on May 12, under chloroform, and with requisite antiseptic precautions.

The uterus was drawn outside the vulva, a strong silk double thread, after the manner of Czerni, was passed from behind forwards by means of a needle, through the middle of the upper part of the pedicle. Each of these threads, em-

bracing one-half of the pedicle, was drawn tight. An india-rubber tube on the stretch was carried twice around the pedicle at the level of the silk ligatures, and passed through the loops of these ligatures. The latter were now tied over the two rolls of tubing in order to prevent its slipping. Finally, section of the tumour was effected by means of the thermo-cautery, one centimetre below the ligatures. After covering the surface of the section with powdered iodoform, it was pushed back into the vagina. A carbolised compress was kept constantly applied over the vulva.

After having stated the consequences of the operation, Dr. Hieguet remarked that complete cicatrisation of the stump had taken place by June 2, and the patient left the hospital on the 15th quite cured.

The author then discussed the various methods of excising the uterus in cases of inversion. After having passed them in review, he referred to the statistics published by West, then those of Denucé, from which it resulted that the operation in which the elastic ligature was employed offered the best chance of success.

In conclusion, he remarked that these statistics related to operations performed partly before and partly after the introduction of new methods of operation and antiseptic dressings; that the late progress of surgery had brought about a great diminution in the mortality. Thus, said he, of sixteen cases of excision of the uterus for inversion, published in the last four years, one only, where the écraseur had been employed, had been followed by death.

M. Craninx did not admit that in every case of complete inversion it was necessary to have recourse to excision, for experience had shown that this accident did not prevent a woman from living many years.

M. Hieguet remarked that he did not sustain the thesis which M. Craninx combated, that in the case he had brought before the Academy the operation had been considered necessary, and that it was the only remaining resource for saving the life of the patient.

M. Thiry imagined that we ought to avoid as much as possible the practice of excision for inversion of the uterus. He had had, he added, to treat many cases of this kind, and had obtained excellent results by practising reduction either with the hand or by means of an apparatus, of which he had given a description in the 'Belgian Medical Press.'

M. Borlée was also of opinion that inversion of the uterus did not in any degree prevent a woman from living a long time. He had known two women who suffered from this infirmity for many years in whom reduction had been tried in vain. They had uterine hæmorrhages and suffered severe abdominal pains. In such cases, he said, he would not hesitate to practise excision. — *Académie de Médecine de Belgique*, July 25, 1885.

CHICAGO GYNÆCOLOGICAL SOCIETY.

FRIDAY, SEPTEMBER 18th, 1885.

I. DUDLEY—**Remarks upon Abdominal and Gynæcological Surgery in England, Scotland, and Heidelberg** (The President, Dr. H. P. MERRIMAN, in the chair).—Professor E. C. DUDLEY made some informal remarks relative to his observations in gynæcological and abdominal surgery, during a summer holiday in Europe. His observations were confined to the work of a few operators in England, Scotland, and Heidelberg.

In Heidelberg, he called upon Professor Kehrer. Professor Dudley inspected the hospital and saw evidence of considerable work in abdominal surgery. Professor Kehrer's laboratory gave evidence of active research into gynæcological bacteriology. His work bore the stamp of thoroughness and efficiency. Professor Kehrer is a medium-sized man, frail and delicate, with a large head and small body.

A call upon Dr. Bantock resulted in a pleasant hour's conversation upon subjects pertaining to ovariotomy and hysterectomy. Patients at the Samaritan Hospital sometimes

die within twenty-four hours after laparotomy, with a high temperature. This condition was called acute sepsis by certain systematic writers. Dr. Bantock thought the true pathology of the condition was unknown, and was not satisfied with the term, acute sepsis. Professor Dudley saw Dr. Bantock operate at the Samaritan Hospital. The first operation was the removal of a small, solid ovarian tumour. The remaining ovary and tube, although normal, were removed on account of a small intra-mural, uterine fibroid. The striking feature of the operation was great rapidity without haste. Dr. Bantock caught up the edges of the peritonæum with small compression forceps, so that these edges were drawn up towards the cutaneous edges, and were held in this position by the weight of the instrument against the abdominal surface. This manœuvre greatly facilitated the passage of the sutures. The pedicle was secured by means of silk ligature, applied in the operator's peculiar figure-of-eight turns.

In closing the wound, a needle of ovoid shape, curved on the edge instead of on the flat, was employed. This needle combines the maximum of strength with the minimum of size. Two or three sutures were passed through at each angle of the wound ; their ends were joined by knots. An assistant, passing the index finger of each hand through the loops thus formed, made traction at each angle of the wound, in such a manner as to draw its sides into contact, and to lift the peritonæal edges nearer to the surface. The introduction of the remaining sutures was in this manner greatly facilitated. The sutures were so closely passed that no superficial stitches were required. They were made to include a very narrow margin of skin and peritonæum, and very little if any muscular tissue. Fine silkworm gut was employed.

The ends of the sutures, on each side of the wound, were now grasped in lock forceps, which prevented them from being drawn out, or becoming tangled during the separation of the wound for the toilet of the peritonæum, which was most thorough, the entire cavity being rendered perfectly clean and

dry. The lock forceps were then removed from the ends of the sutures, and the hands of the assistant substituted. The action was thus made on all the sutures, in the direction of the upper angle of the wound, and they were tied in order from below upward and cut short. This prevents tangling of the threads and otherwise facilitates tying. Antiseptics, throughout the operation, were conspicuous by their absence. The dressings were of the most simple character.

Dr. Bantock kindly showed Professor Dudley over the hospital, which contained a number of convalescents from hysterectomy, ovariotomy and oöphorectomy. Dr. Bantock's exceptionally good results, in the last operation, are recognised throughout the world. His wonderful statistics in abdominal surgery are due to downright splendid operating. Dr. Meredith, at the same time, was removing a tumour in another room, under the most extreme antiseptic conditions. The famous Samaritan Hospital is an unpretentious building, seemingly a large reconstructed dwelling, in the middle of a block, with houses joining on either side, and, like great men, has a modest appearance.

It is generally supposed in America that the Woman's Hospital in the State of New York, established by Marion Sims in 1855, was the first of its kind in the world. This is a mistake. Dr. Sims himself, in a letter to Dr. Protheroe Smith, of London, dated July 1883, accords to that gentleman the honour of having established the first hospital specially for the treatment of the diseases of women. This hospital, founded in 1842, is now a flourishing institution in London, and is called the Hospital for Women.

Its venerable founder visited Chicago a year ago. Professor Dudley again met him in London. His enthusiasm for the specialty, in which he has been a pioneer, continues—indeed, seems to increase with advancing years. He retains his official connection with the institution, as senior physician, and is still engaged in active practice. He was among the first, against bitter opposition, to advocate anæsthesia in labour. Efforts are now being made, with great promise of

success, to raise funds for the construction of a larger and more appropriate hospital building.

Professor Dudley visited Birmingham, in response to a polite telegraphic invitation from Mr. Lawson Tait. On the train he occupied the same compartment with a sleek, well-fed, high-church London clergyman of the most conservative order, who intimated in no uncertain manner that the conservative people of London looked down upon the inhabitants of the radical city of Birmingham as a semi-barbarous community. So decided were his denunciations of the radical party in general, and of Birmingham in particular, which as the chief stronghold of radicalism always returns John Bright and Chamberlain to Parliament, that Professor Dudley in an apologetic manner explained that he was only going into the jaws of the Philistine to witness an operation by a distinguished surgeon, from whom he hoped to learn something. The clergyman inquired who the surgeon was, and upon hearing the name of Lawson Tait, exclaimed: 'O, I know all about him; he is just as bad as any of them:' which means that Mr. Tait is a radical in politics, as he is in surgery.

Mr. Tait's ridicule of antiseptics is well known. His rapid method of operating conveys to the casual observer the idea of haste and almost of carelessness.

But closer observation very soon shows him to be one of those rare operators, where dexterity amounts almost to a sleight of hand. An ovariotomy, in his hands, does not impress the observer as a capital operation. It seems almost as trivial as opening an abscess. His methods of operating did not materially differ from those of Dr. Bantock. In closing the wound he used but one needle, threaded with a piece of long silk, introducing this as if for a continuous suture, but did not draw the thread tight. After the introduction of the needle, he left a long loop before the reintroduction. Then, after taking the last stitch, he lifted the free loops of silk on the index finger, and severed them with the scissors, thereby converting the continuous into an interrupted suture. These

were tied in the ordinary way, and the wound was dressed in a manner which would be eminently acceptable to his most bitter antiseptic enemy.

During the day, Mr. Tait performed ovariotomy, lumbo-colotomy, perinæorrhaphy, and excised a urethro-vulvar cyst, besides attending to a large number of consultations, in one of which Professor Dudley accompanied him to a distance of forty miles. This was for him only a moderate day's work. It is indeed evident that no other man in England controls a larger practice in abdominal surgery.

Mr. Tait impressed Professor Dudley as a sincere man of exceptionally strong and positive character and very much in earnest. Like Virchow he is politically inclined ; indeed, his temperament is such that he cannot see things go on without having a hand in them. He has taken active part in the city government of Birmingham, and, as Professor Dudley was informed, had already declined to stand for Parliament.

During a brief visit in Edinburgh, Professor Dudley was pleasantly entertained by Dr. Thomas Keith, who had just returned from a consultation with Dr. Homans in Boston, but unfortunately Dr. Keith did not operate during this time, although a large number of patients were waiting for him at the Royal Infirmary. His son, Dr. Skene Keith, kindly invited Professor Dudley to an ovariotomy, his forty-eighth operation. Up to this time, he had only lost one or two patients. His operation presented some interesting peculiarities. He used probe-pointed scissors of a peculiar pattern, instead of the director, in going down through the deeper layers of the abdominal walls. By pressing firmly against the adhesions with a sponge, at the point of their attachment to the cyst, he literally sponged them away from the tumour. It was surprising to note the facility with which rather firm adhesions were thus broken. It is much easier to tear them from the tumour with the sponge than to tear the tumour from the adhesions. The breaking of the adhesions in this way is also much more gentle, and, in the opinion of Dr. Keith, diminishes the danger of shock.

The adhesions were ligatured with fine catgut as fast as they were divided. In passing the ligatures a forceps, similar to the ordinary compression forceps, was used. This instrument had blades more than an inch long, of very small diameter, terminating in sharp points, so sharp that when the blades were closed they could be thrust through any soft tissue like a large needle. Grasping the ligature in the point of these blades, the tissue to be ligatured was transfixed. The ligature was then pulled through and the forceps withdrawn.

The pedicle was transfixed and ligatured, with fine silk, in the same way.

The cautery, to which much of the elder Keith's success has been attributed, was not employed in this case, because the pedicle was very slender. The reason why the cautery, in the hands of other operators, has not proved a more perfect protection against hæmorrhage, becomes apparent to any one who has witnessed its application in the hands of Dr. Keith. The whole secret of his method is, first, in the powerful compression of the pedicle between the broad blades of a heavy Baker-Brown clamp; second, in the prolonged application of the red-hot cautery iron, not only to the pedicle, but, after this has been burned to the level of the clamp, also to the clamp itself. In this way the clamp becomes so hot that the included portion of the pedicle is slowly and thoroughly cooked, so that when the instrument is removed, the end of the pedicle is thin and translucent, resembling a horny substance. Such a pedicle, in the experience of Dr. Keith, never gives trouble from oozing.

The wound was closed with fine silk sutures which had been boiled. Ten or fifteen pieces of silk were threaded at each end with very finely well-tempered needles nearly three inches long, which were introduced on either side from within outward. Very small margins of peritonæum and skin were included in the sutures. Dr. Keith thought it a very common fault among operators to draw the stitches too tight in tying. The long fine needle used in closing the wound is superior. It makes a very small puncture, which never bleeds, and is so

fine that it is easily pushed through by means of finger and thumb without needle forceps.

In the 'American Journal of Obstetrics,' April 1880, Marion Sims had given a remarkable description of the Keith operation, which has exerted a powerful and beneficent influence upon the operation in America. Professor Dudley could add little except the gentle handling of the adhesions with the sponge, the ligature forceps and the peculiar long straight needles already mentioned.

The wonderful success without antiseptics recorded by the great Scotch ovariotomist, by Dr. Bantock and by Mr. Tait, who have reduced the mortality almost to zero, must have great influence in fixing the value of Listerism so far as it relates to abdominal surgery. At any rate, incompetent operators can no longer venture with impunity upon these capital operations under the dangerous impression that in some mysterious way antiseptics will deprive a crude surgical performance of its greatest perils. Evidently it was not so much a question of Listerism as of removing the tumour with the least possible amount of operating, and in the shortest time consistent with careful attention to detail, and in the most gentle manner.

Professor Dudley, however, raised the pertinent question, whether Listerism should be placed on trial before a court of abdominal surgeons, and whether, if found unnecessary in peritonæal surgery, it could be fair to condemn it in general. He thought that such a verdict could not be sustained by the facts, but that the antiseptic principle in surgery was destined to stand. Even the most violent opponents of antiseptics agreed that perfect cleanliness was essential. He knew of no other method by which cleanliness could be rendered so nearly absolute. Nor did the seeming ability of two or three of the most dexterous operators to do without antiseptics prove that it might not be a useful aid to others. Clearly, the man who removes a tumour with the least operating and handling of the parts will require fewer preventive measures against inflammation and sepsis. Antiseptics, therefore, might be most

valuable for an inexperienced operator, and, to say the least, an additional safeguard for any one.

Some American operators were now having about as good results as could be shown in Great Britain, which seemed to indicate that our former high mortality in this American operation had been due in reality to bad operating, and not, as many supposed, to climatic causes.

The minor gynæcology of Great Britain had apparently made but little progress since the days of Bennett and Simpson. The general impression prevails that on this side of the Atlantic we are going wild in the minor gynæcological surgery. In response, we may now congratulate our English brethren that many of their leading gynæcologists are already commencing to comprehend, to appreciate, and to perform the American operations of perinæorrhaphy, elytrorrhaphy and trachelorrhaphy, and at the same time to lay aside in a measure the old *porte caustique.*

DISCUSSION.

Dr. H. P. NEWMAN said that there were other reasons for the brilliant success of foreign laparotomists than those referred to by Dr. Dudley. Aside from the facility and expeditious manner of operating, acquired by large experience, a prime factor is the justifiable self-confidence of the operator and a responsive confidence inspired in the patient.

Professor W. W. JAGGARD thought that minor gynæcological operations, as Professor Dudley termed them, were less frequent in the United Kingdom and the Continent than in America. Professor Dudley had made this general assertion, and he agreed with him. He did not, however, think the operative skill of British or Continental surgeons inferior to that of their American *confrères.* The indications for operative procedure do not exist in the United Kingdom and the Continent as in America. Laceration of the cervix and perinæum are of much less frequent occurrence. The *cervix uteri* is usually effaced, and the external os is fully dilated before the application of the forceps. Manual dilatation is

less frequently practised. The bag of waters is not prematurely ruptured. Greater care is taken with the preservation of the perinæum. In a word, obstetricians are better operators, and do not require so-called gynæcological assistants.

Dr. E. J. DOERING said that, in 1874, he had been present at ovariotomy and other operations, performed at the Samaritan Hospital by Sir Spencer Wells. He was particularly impressed with the extreme care exercised in admitting spectators to the operations, each visitor being required to sign a statement that he had not made an autopsy or attended a case of contagious disease for the two or three days preceding. He desired to know whether these regulations were still in force, and also if Mr. Lawson Tait and Dr. Keith required similar restrictions.

The PRESIDENT asked the following questions:

1. 'Was any treatment given to the patients to prepare them for the operation by any of the eminent gentlemen mentioned?'

2. 'How were the patients covered during the operation, or was the whole abdomen left bare?'

3. 'How was the evacuation of the cyst managed?'

4. 'Was the patient turned upon her side to accomplish this, as Dr. Thomas sometimes does?'

The President suggested that all who desired should ask questions for further light before the general discussion began.

Professor CHRISTIAN FENGER replied to the question, raised by Professor Dudley, that antiseptic precautions might be more important in surgery, in general, than in abdominal surgery, where it looked as though more perfect methods of operating without antisepsis gave as good results as with antisepsis, as follows:

He thought that the abdominal, or rather peritonæal cavity, in respect to the antiseptic precautions, occupies a peculiar position in surgery. The danger from absorption of the poisonous antiseptics is far greater in the abdomen than in wounds. The ability of the peritonæum to absorb serous

fluid and blood before it decomposes, to encapsulate foreign substances not capable of absorption—ex. gr. rubber ligature—is perhaps somewhat greater than the ability of a wound in that direction, although it may be that there is some prejudice about this, as we have not as yet used silk ligatures extensively in general surgery.

As to the question, whether more perfect methods of operating without antisepsis would improve the results, or rather prevent inflammation and sepsis, he could say that outside of the peritonæum this question must as yet be answered in the negative.

In 1873, Volkmann, of Halle, introduced the Lister method of dressing and operating in his surgical clinics. In his report of the work done in 1873 (*Beiträge zur Chirurgie* 1875), the antiseptic surgery had reduced inflammatory and septic complications following excisions, amputations, fresh penetrating articular wounds, fresh open fractures, to a minimum never before dreamt of, and all this in one year. In the broad field of surgery it is not possible that Volkmann or anybody else could improve the *technique* of operating to the extent of having the results change all of a sudden in that way. No surgeon would dare, to-day, to excise, for example, a knee-joint without antiseptic precautions in all the minute details, even if he employed all the latest improvements in the method of operating. Abdominal surgery is the only branch of surgery in which, as yet, the heavy operating has been done without antiseptic precautions.

W. W. JAGGARD, M.D., *Editor.*

2330 Indiana Avenue.

CLINICAL AND PATHOLOGICAL REPORTS.

CHELSEA HOSPITAL FOR WOMEN. OVARIOTOMY, REPORTED BY DR. FOURNESS SIMMONS.

B. T., æt. 62, married, mother of ten children, was sent into the Hospital by Sir Alfred Roberts, of Sydney, under the care of Dr. Fancourt Barnes, on August 26, 1885. The patient first noticed a swelling in the abdomen two years previously. Ten months before admission she was tapped. The circumference of the abdomen at the umbilicus was 46 inches. The sound passed 3 inches into the uterus in the normal direction. For some years past she had suffered from attacks of renal colic in the left kidney at varying intervals. On September 3, the patient having been placed under ether, Dr. Fancourt Barnes opened the abdomen under the carbolic spray. In consequence of the tumour having been tapped, its entire anterior aspect was firmly united to the abdominal wall by strong fibrous adhesions, which required considerable force to break down. This done, the trocar gave passage to 480 ounces of a deep olive-coloured fluid, having a crystalline sediment. The remainder of the tumour, which was solid and weighed 14 lbs., was then drawn out of the abdomen. The pedicle was transfixed and tied with a China silk ligature, and the tumour removed. The toilet of the peritoneum occupied rather longer than usual in consequence of the numerous adhesions which had been broken down. The abdominal incision, which, on account of the enormous size of the tumour, measured 8 inches, was brought together by silver sutures, with Aveling's coil and shot. The usual antiseptic dressings were applied, and the patient put to bed. The operation lasted 40 minutes.

The history of the pulse from the day of the operation presented nothing abnormal beyond the fact of its uniformly intermitting at every fourth beat. This persisted until she left the hospital. There was a well-marked presystolic mitral murmur.

The temperature was 101·6° F. on the evening after the operation, falling on the following day to 100·8°. On the third evening it

reached 101·8°. On the fourth evening it rose to 102·8°, and fell to 99·6° on the morning of the following day. On September 21 the temperature suddenly rose to 101·6°, coincidently with the discharge of 8 ounces of most offensive pus from the left kidney, which could be distinctly felt enlarged.

In spite of the patient's advanced age, the unusual size of the tumour, extreme emaciation, cardiac lesion, and old-standing kidney mischief culminating in nephritic abscess, she was able to get up on the twelfth day after the operation, and left the hospital in excellent health fifteen days subsequently.

Inversion of the Uterus: Probable Cause, Tight-lacing. By J. E. Dunn, M.R.C.S., L.R.C.P., Preston.

On Saturday, March 14, 1885, I was summoned to M. S., aged 35 years, single, primipara, by her father, who stated that the midwife had sent him asking for my immediate attendance. On my arrival I found the patient cold and clammy, but still perfectly conscious, pulse exceedingly weak; she had been delivered of a full-term living male child; the cord had been divided.

On examination I found extruding from the vagina the placenta intact, and adherent to a pyriform mass, the size of a child's head. There had evidently been much hæmorrhage. I carefully peeled off the placenta, and before doing so I gave a drachm of ext. ergotæ liq. B. P., and half an ounce of brandy. The hæmorrhage had then ceased.

Seeing that it was a case of inverted uterus, I proceeded at once to reduce it by firm and continuous pressure of the hand upwards and backwards in the direction of the pelvic curve.

For eight minutes it did not offer to yield, but at the expiration of that time it gradually returned, and at the end of a quarter of an hour I succeeded in completely reducing it, so that I could feel the patent os uteri. I introduced my finger and found that the fundus was not at all inverted.

The uterus then firmly contracted to the size of a cricket-ball, and a binder and pad were then applied.

The patient still remained perfectly conscious; brandy and milk were administered *per rectum*, brandy and beef-tea by the mouth, and fifteen minims of sulphuric ether were injected subcutaneously.

At 9.45 A.M. the patient rallied considerably, and had the rites of the Catholic Church administered to her.

As time rolled on she became unconscious, and at 10.5 A.M. she showed all the marked signs of shock.

Examining her again I found the fundus of the uterus protruding through the os, and carefully replaced it, again injected brandy and beef-tea, and applied heat to the extremities and sides.

At 10.45 A.M. the patient died.

On examining her *per vaginam* after death I found the uterus *in situ*, and its axis normal.

Unfortunately the friends would not allow the abdomen to be opened.

Family history good. Patient herself always strong and healthy. Own mother did not know of her state until three weeks prior to her confinement, owing to the fact that she laced herself indescribably tight, both night and day, in order to conceal her condition. The midwife, whom I know from experience to be always careful and reliable, informed me, and her statement is corroborated by the mother, that the patient slept up to 4.30 A.M., and at 5.30 A.M. the midwife was sent for and removed the stays, which were then tightly laced, and had been so all through the night.

The pains were at first feeble, and she would not allow an examination until 7 A.M. The pains then increased in severity. The waters broke about 8 A.M. spontaneously, only a small quantity of liquor amnii escaping.

The pains increased up to 8.30 A.M., when the child was easily expelled.

The division of the cord was performed, and before the child could be lifted away a large mass was expelled which both the mother and midwife 'thought to be another child,' inverted uterus with placenta attached.

No binder was applied to the abdomen prior to delivery.

The midwife assures me that there was no traction on the cord at all.

Remarks.—I record this case, as I firmly believe it to be attributable to tight lacing.

Inversion of Uterus—Reduction by Aveling's Repositor.

A. N., æt. 24, was confined with her second child on September 25 last (1884), under the care of a midwife. According to the patient's statement, the midwife told her that 'the child and after-birth came away all right.' She felt very well for about ten minutes after this birth; she then became very faint, and lost

consciousness for several hours. The medical man who was called in on the occurrence of this condition, writes :—'She was delivered by a very careful and competent midwife, who described the whole labour as extremely easy and natural. I was sent for about an hour afterwards on account of post-partum hæmorrhage. On examining I immediately came on the projecting mass in the front wall of the vagina, but I pushed my hand and arm behind and above it into a large cavity filled with clot, which I cleared out, and then injected with perchlor. ferri. This stopped the bleeding, but it recurred once in serious amount during the time she remained here. She had been taking a good deal of ergot during the first month.' The further history obtained from the patient is that for three weeks she had scarcely any discharge; then she had a copious flow for about a week, for which ice was used. After an interval of four weeks the period returned, the flow being very free, with many and large clots, and on the sixth day—viz. on November 24—she entered the Samaritan Free Hospital under my care. That night she had very free hæmorrhage. Next morning, after a copious hot douche, I examined her and had no difficulty in diagnosing inversion of the uterus. The patient was in a very anæmic condition and very weak, and, desiring to lose no time, in the afternoon of the same day I attempted to reduce the organ by taxis under chloroform. I could reduce the uterus almost within the os, but the fundus would not give way, and after what I deemed a fair attempt, I applied Aveling's Repositor and put her back into bed, not, however, without noticing that I had ruptured the mucous membrane of the recto-vaginal septum for about two inches longitudinally from the perineum by the introduction of the hand. Next morning the Repositor was removed, the vagina was washed out with a weak solution of iodine, and the uterus was found as before. The Repositor was reapplied for about eight hours. I then thought it prudent to discontinue the effort at reduction until the vaginal tear had healed. So far there had been no constitutional disturbance. The vagina was washed out twice daily with the iodine solution. On the 30th I put her on tinct. fer. mur. P.E. (mx.) and extr. erg. liq. (mxx.) three times a day. The diet consisted of an abundance of milk with some farinaceous food.

On December 10, the vaginal rent having quite healed over, I invited my friend Dr. Aveling, who I knew took much interest in these cases, to see my patient. It had already occurred to me that the elastic bands supplied with the instrument were much too weak, though stretched to their utmost, and Dr. Aveling at once found the

same fault with them. Stronger ones, about a quarter of an inch in width, were procured, and Dr. Aveling applied the instrument. Next morning the uterus was still unreduced, and after the vagina was well washed out with the iodine solution, the instrument was re-applied. About three hours afterwards the patient began to complain of pain, and the nurse administered $\frac{1}{6}$ gr. morphia subcutaneously. At five o'clock I found that the uterus had become reduced, and that the cup of the instrument was quite within the os, from the grasp of which it was relieved by a little manœuvring. After its removal the uterine cavity was well washed out with the iodine solution.

The patient returned home on the fifteenth, feeling wonderfully well, and complaining of nothing. The uterine cavity measured $2\frac{1}{2}$ to $2\frac{3}{4}$ inches.

This case calls for but few remarks.

There is no evidence that the accident was due to any act of the midwife. I think we must assume that the flooding was the result of the inversion, and that the doctor was mistaken in imagining that his hand had entered the uterine cavity; for he speaks of 'a projecting mass on the front wall of the vagina.' This was evidently the uterus. Nor did he at any time recognise the nature of the case. The result points to the great value of the principle of continuous pressure, when rightly applied, and its superiority over the method of taxis.

GEO. GRANVILLE BANTOCK.

CORRESPONDENCE.

To the Editor of the British Gynæcological Journal.

SIR,—I was much interested in reading the account of the fœtus which you showed at the meeting of the British Gynæcological Society on April 22. In the summer of 1866 I was called to a woman who had just been delivered, at full term, of a nine months' child, completely enveloped in the membranes, with placenta attached, just as in your case.

The rarity and great interest of these cases will, I trust, be an excuse for my intruding on your valuable space.

I am yours faithfully,

HENRY M. JAY.

Chippenham, Wilts:
September 20, 1885.

To the Editor of the British Gynæcological Journal.

SIR,—In my paper on sloughing of the vagina with septicæmia, published in the 'Journal' of July, I ventured to suggest the possibility of the puerperal poison infecting those in attendance, and that, too, in a variety of forms. In support of my suggestion I recorded that three people, who were in close attendance upon my patient, suffered from symptoms of blood-poison, one having an angry pustule, another erysipelas in the legs, and the third severe and persistent skin irritation. I have now to note that a fourth individual, the husband, has to be added to the list. Although not of robust health, his chest had never given him any trouble. He was much in his wife's bedroom during her illness. He had contracted no marked cold or inflammation, but about two weeks after her recovery he began to be troubled with a cough; about four or five weeks later he began to lose flesh; by the middle of May he had developed undoubted phthisis—wasting of flesh, cough, high temperature, quick pulse, blood-spitting, dullness of right apex, loss of appetite, loss of

weight to the extent of eighteen or twenty pounds, and weakness—a condition which, more or less, continues to this date. Dr. G. A. Heron has kindly examined for me the sputum of this patient, and finds in it a number of tubercular bacilli of large size, and marked by numerous spores. This, no doubt, proves the nature of the case, and, in the opinion of many, the presence of the specific bacillus would at once disprove my hypothesis; but I fancy sufficient uncertainty still exists as to the origin of tubercular phthisis to justify me in drawing attention to the association of phthisis with puerperal septicæmia. This onset of phthisis may only be a coincidence, but, on the other hand, it may be dependent on the puerperal poison, and at least it will be admitted that the recording of such associations may help towards the better understanding of disease.

I am yours faithfully,

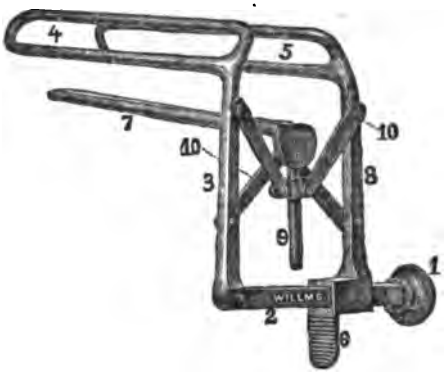
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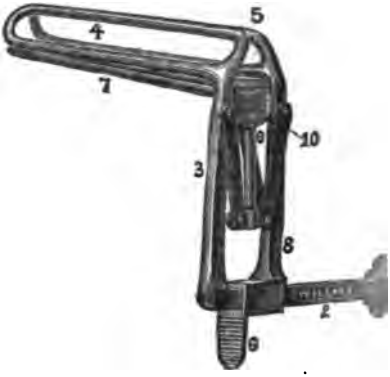
29 Keppel Street, W.C.:
August 27, 1885.

NEW INVENTIONS.

A New Self-Retaining Rectal and Urethral (Female) Speculum. By ROBERT T. WILSON, M.D. (Baltimore, Md., U.S.A.), Assistant-Surgeon Woman's Hospital of Maryland; Gynæcologist to the Union Protestant Infirmary.

THIS speculum, as will be observed by the cuts below, consists of three fenestrated blades, one of which, 4, is connected by its proximal end to a shaft 3, which is joined to the rectangular bar 2.





The second blade 5 is connected with the rectangular bar by means of the slide 6.

The third blade, 7, is fastened by four crossbars, 10, to the blades 4 and 5. It will be observed in the cuts that the third blade is provided with a shaft, 8, moving in a guide, 9, attached to the upper crossbars, thus preventing rotary motions of the third blade.

The blades are introduced closed; pressing the pressure-piece 1 and the slide 6 toward each other will expand the speculum as far as the urethra or rectum will admit of, and the pressure of the walls upon the extremities of the blades will hold the slide stationary at

any desired point of dilatation. Lightly pressing on the slide 6 will release the blades from their fixed position.

The simplicity of the construction of this speculum, and the ease with which an examination can be made with it, have induced me to present it as an additional aid in the diagnosis and treatment of rectal and urethral diseases.

Its construction, except in regard to the third blade, is upon the same principle as that comprised in the useful and ingenious eye-speculum of Professor Russell Murdoch, of Baltimore; he describes his speculum in the 'Transactions of the American Ophthalmological Society' for 1883. This speculum is made by Willms & Co., of Baltimore.

Forceps usus in tumorum operatione ad perforationem et filum pertrahens.



THE instrument here shown by the cut is offered as an additional help in removing tumours from the abdomen.

In some cases it is safer for placing the ligature than the needle.

It is made by Willms & Co., of Baltimore.

NOTES.

Professor Giuseppe Chiarleoni has recently published a translation into Italian, from the second edition of Dr. Fancourt Barnes' 'Manual for Midwives.'

The following distinguished Gynæcologists have been elected Honorary Fellows of the British Gynæcological Society: — Dr. Fordyce Barker, of New York; Professor S. Tarnier, of Paris; Dr. Albert Holmes Smith, of Philadelphia; Dr. T. A. Emmet, of New York; Dr. Gaillard Thomas, of New York; Dr. W. Goodell, of Philadelphia; Professor Porro, of Milan; Professor Winckel, of Dresden; Dr. Gallard, of Paris; Dr. Martin, of Berlin; Dr. Schroeder, of Berlin; Dr. Crédé, of Leipzig; Dr. Hegar, of Freiburg; Dr. Hugenbeger, of Moscow; Dr. Lazarewitch, of St. Petersburg; Dr. Howitz, of Copenhagen; Dr. Harvey, of Calcutta; Professor Koeberlé, of Strasbourg; Professor Carl Braun, of Vienna; Dr. T. Keith, of Edinburgh.

Dr. Robert Barnes has been appointed Consulting Obstetric Physician to St. George's Hospital. This is the first occasion, at this hospital, on which the retiring Obstetric Physician has received the honorary post.

The Treasurer would feel obliged if those gentlemen who have not yet forwarded their subscription for the current year would do their earliest convenience. Cheques or Postal orders may be made payable to

ARTHUR W. EDIS,
22 Wimpole Street, W.

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NOTICE.

Volume I. of the "British Gynæcological Journal," comprising Parts 1 to 4, is now ready, bound in Half-Vellum, Price 14s.

Cases for binding the Volume may be had, price 3s.

London : SMITH, ELDER, & CO., 15 Waterloo Place.

INGLUVIN

IN CASES OF DIARRHŒA, CHOLERA INFANTUM, & MARASMUS

The prevalence of Cholera Infantum, Cholera Morbus, and Diarrhœa, to a greater extent during the summer period, induces us to call the attention of the medical fraternity to the above well-known and introduced remedy 'INGLUVIN.' It has been used in practice with very happy results for a considerable time. We find Indigestion generally at the bottom of bowel complaints, which INGLUVIN has almost instantly corrected alone or in combination. It is given in the following formulas with great advantage:

INFANT FORMULA.		FOR ADULTS.	
Ingluvin gr. xii. Sacch. Lac. gr. x.	℞ Aqua Calcis..... f 3 ij. Spts. Lavand. Comp., Syr. Rhei. Arom. aa f 3 j	℞ Ingluvin 3 j. Morphia Sulph. gr. jss.	℞ Aqua Calcis..... Spts. Lav. Comp. Syr. Rhei. Arom.
Misce et Ft. cht. No. x.	Tr. Opii.....gtt. x.	Misce et Ft. cht. No. xii.	Tr. Opii
Sig.—One every 4 hours.	Misce. Sig.—A teaspoonful every 2 to 4 hours.	Sig.—One every 4 to 6 hours..	Misce. Sig. — D... spoonful ever... hours, or after... evacuation.

In inflammatory affections, INGLUVIN is combined with Subnitrate of Bismuth, &c., parts, and oleaginous mixtures with Ol. Terebinth, instead of Aqua Calcis. Should the evacuations be suddenly arrested, and tympanites supervene, follow with a dose of oil of magnesia, or injections. In many cases of sick headache and indigestion, the most beneficial results follow from the combining of INGLUVIN with Pv. Nux Vomica, the one-twentieth to one-tenth grain.

Marasmus successfully treated with INGLUVIN.—See Article below.

TABEO-MESENTERIC DISEASE.

1 ELDON SQUARE, NEWCASTLE-ON-TYNE, ENGLAND,
October 31st, 1880.

DEAR SIRS,—Will you have the kindness to inform me if you have an agent in this town for WARNER'S INGLUVIN, as I shall most likely prescribe it from time to time, in order to give it a more extended trial. I was much gratified with its action in a distressing case of Tabeo-Mesenteric Disease. I had no difficulty in bringing the pain under subjection by opiates, &c.; but in the vomiting, emaciation, and disordered condition of the bowels, there was no improvement. Finding a sample box of INGLUVIN upon my consulting table, for which accept my thanks, for I firmly believe that the powder saved my little patient's life). I gave the mother the box containing a dozen powders, requesting her to divide one into three, and administer one to it daily. The pain disappeared, the vomiting ceased, flesh was rapidly put on, and in the short space of a fortnight the patient (previously under treatment for six weeks) was convalescent and completely recovered (aged 2½ years).

Believe me, yours faithfully,

ANTHONY BELL, L.R.C.P.Ed., M.R.C.S.Eng., L.S.A., &c.
Late Senior Assistant to the Newcastle Infirmary, and Surgeon to the
Hospital for Diseases of the Skin, &c.

PER BOTTLE 4s. 6d.

WARNER & Co.'s Ingluvin, Parvules, Sugar-coated Pills, and other Preparations may be obtained of the following, in addition to many others:—Grattan & Co., Belfast; Duncan, Flockhart, and Raimes & Co., Edinburgh; Evans, Sons, & Co., and Symes & Co., Liverpool; T. R. Lester, Cork; Anderson & Adams, and McMaster & Co., Dublin; Lofthouse and Sanderson, Hull; Davidson & Kay, Aberdeen; New Apothecaries' Company, Glasgow; also in London, of Messrs. Barclay & Sons, Butler & Crispe, W. Edwards & Son, J. Sanger & Sons, W. Sutton & Co., Corbyn & Co., &c.

SOLE DEPOT IN GREAT BRITAIN:

F. NEWBERY & SONS

(125 YEARS IN ST. PAUL'S CHURCHYARD),

1 KING EDWARD STREET LONDON, E.C.

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THE BRITISH

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THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, NOVEMBER 11, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 39 Fellows, 4 Visitors. The following gentlemen were elected Fellows of the Society:—Dr. F. A. N. Bateman, Dr. J. H. Condon, Dr. C. H. Walker, Dr. W. T. Lusk, Dr. J. A. M. Thomson, Dr. F. W. D. Long.

The following gentlemen were proposed for election:—Dr. P. Budin, Paris; Alfred Cooper, F.R.C.S., London.

Mr. LAWSON TAIT showed preparations from two cases of cholecystotomy upon which he had operated for the presence of gall-stones. They illustrated the characteristic differences between the two groups into which he had divided cases of this disease—the large solitary gall-stone and multiple small gall-stones. In the former he found the gall-bladder distended and containing about a pint of pus; the sufferings had been very considerable. The gall-stone was impacted in the neck of the gall-bladder, and had to be broken up in the removal. In the other case the gall-bladder contained a small quantity of bile and eight gall-stones. The patient

had suffered at intervals of two or three months for several years from violent spasmodic attacks of pain. The operation in this case was undertaken entirely from the symptoms, as there were very little of any physical indications of trouble. These patients constituted the nineteenth and twentieth cases of cholecystotomy which Mr. Tait had performed, and all the twenty cases have recovered.

Dr. EDIS exhibited a combined hydro-salpinx and cystic ovary blended into a pyriform-shaped mass, which he had removed on the 9th from a patient in the Chelsea Hospital for Women, on account of severe dysmenorrhœa, dyspareunia, inability to stand or walk, dyschezia, constant pain in the pelvis, &c. The patient was thirty years old, married nine years, sterile, and was quite unable to perform her household duties. Various methods of treatment had been tried by others before she came under observation, but nothing had alleviated her sufferings in the least. The cystic swelling was bound down firmly in the pelvis, to the right of the uterus. An incision two inches long was made in the median line, and the cyst enucleated from its bed by breaking down the adhesions and removed entire. It contained two ounces of clear, limpid fluid, which showed no traces of albumen on boiling, but became cloudy on adding nitric acid. Its specific gravity was 1010. The patient was doing well.

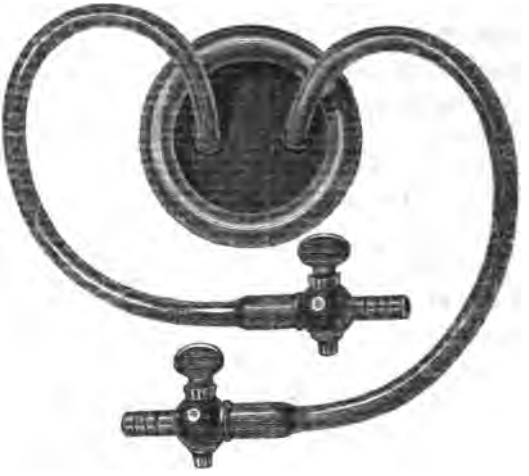
Mr. LAWSON TAIT only could say that it was a characteristic example of hydro-salpinx. If the Fellows would look at the preparation closely, by the point where the tube was tied, they would see what Mr. Tait had ventured to call the mammilla—that is, the divided end of the tube being composed of three layers, the two outer layers contract, so that the inner or mucous lining of the tube projects out, forming a nipple-like process. If the ligature were undone and the bag of fluid squeezed out of this mammilla, a small fountain of fluid could be made to play. This is precisely the kind of case that wanders about from hospital to hospital, from consulting room to consulting room, seeking relief and finding none, until it fortunately falls into the hands of

some surgeon who will open the abdomen and remove the disease.

Dr. BANTOCK exhibited the fragments of a tumour, the size of a small walnut, which he had removed about ten days previously from a widow woman aged 55. The symptoms began in March last, in the form of pain in the hypogastrium, with painful and frequent micturition. At last the symptoms had become so severe that the poor woman was unable to get any rest, night or day. The urine contained a large quantity of blood, with a great deal of mucus and phosphates, and was intensely ammoniacal. On dilating the urethra by means of Simon's dilators, the tumour was found situated on the right floor of the bladder. After partial separation by the finger-nail, it was removed in successive portions by means of a pair of polypus forceps. It was so pliable that the moment the forceps was compressed the portion seized came away in the instrument. The result up to the present time is that the pain and frequency of micturition have been very much relieved. Unfortunately, however, the tumour is an epithelioma, and the ultimate result cannot be doubtful.

Dr. IMLACH showed the apparatus employed by him for prolonged vaginal irrigation. It was a spring pessary with a rubber diaphragm into which two rubber tubes, each a foot long, were inserted flush with the surface, and both influx and efflux tubes terminated in a tap. After the pessary had been inserted within the vulva a yard of tubing was attached to each tap. The influx tube was thus connected with a two gallon jar placed on a table beside the bed or chair occupied by the patient, while the efflux tube hung over a pail. In cases of disease of the cervix uteri and of recent pelvic inflammation, he had often continued the irrigation for long periods without intermission. A nurse in attendance was required, as the flow was six gallons in the hour, though it could be diminished by turning one of the taps. When the ordinary vaginal douche or any of the rather expensive vulvar cups were employed, few women could bear the injected fluid at a higher temperature than 105° or 107°, and the labour

was so troublesome that they were seldom used for longer than half an hour each day. With his instrument a temperature of 120° could be borne without pain. Sometimes various disinfecting solutions were used, but often only hot water during the greater part of the time. He generally began the treatment early in the morning, and it was continued until evening. If the patient was able she sat, reading or sewing, on a low chair, but if not she lay on a couch. In the evening the extra tubing was removed, and glycerine (to which any required medicament could be added) was injected through



one tap until it flowed out at the other. Then both taps were turned off and the cervix uteri was left in this glycerine bath all night. Next morning the irrigation was recommenced, and the pessary was not removed until the course of treatment was concluded. In recent pelvic inflammation the relief from painful symptoms, when the method of continuous irrigation was employed, was far greater than what he had ever obtained by the intermittent and occasional douche. In cervical catarrh this method was sufficient, except when there was considerable laceration of the cervix uteri. And in cancer of the uterus fœtid discharge and pain were mitigated. He thought the apparatus would be found to be of service in

obstetric practice. It was simple and cheap, and could be made of different sizes by any instrument-maker. It had been made for him by Messrs. White & Wright, Liverpool.

On the Treatment of Prolapsed Ovaries by Oöphorraphy. By FRANCIS IMLACH, M.D., Honorary Surgeon to the Liverpool Hospital for Women.

Though the term prolapse of the ovaries is only topographical, it has a connotation of intermittent or chronic pelvic pain, of irregular menstruation, of inability to walk without distress, of painful defæcation, and frequent reflex vomiting. In the absence of these symptoms the condition of prolapse is a mere clinical curiosity without practical importance; but their relief, when present, is an acknowledged difficulty, and I have known the removal of prolapsed ovaries to be advised even by those who vehemently denounce the operation of removal of the uterine appendages for inflammatory diseases of the tubes and ovaries. In these painful cases of prolapse there is often more than displacement; the ovaries and tubes may be thickened and adherent by past inflammatory process to the posterior uterine wall or in Douglas' space. Sometimes the ovaries are even adherent to each other, while the uterus is retroflexed and adherent to the sacrum, and there is more or less serous effusion. Such cases seem very common, and, as medicine fails to relieve symptoms, they are often sent to hospital. In many of them the tension and distortion of the parts is probably the sole or at least the chief cause of pain. Chronic ovaritis, unassociated with tubal disease, is often comparatively painless; there is dull aching when the ovaries contain blood cysts, and the power of walking is affected when they lie in the pelvic floor, but there is no acute and unendurable pain unless the ovaries are adherent and the tubes are stretched or distended. I have frequently removed ovaries in which scarcely a particle of healthy structure could be detected, where there was no history or evidence of acute pain. I removed them because they

appeared to be the cause of ill-health and the physical source of morphia and spirit craving. But there are degrees and kinds of ovaritis. While I am unable to believe that chronic ovaritis is more curable than chronic Bright's disease, I think no one would maintain that chronic ovaritis forthwith destroys the ovarian function any more than chronic renal disease completely destroys the function of the kidneys. While the thickening of the parenchyma is only partial and the Graafian follicles are not wholly replaced by shrivelled thick-walled cysts, ovulation continues and pregnancy may occur. It is true that pregnancy is often exhibited only in the frequent recurrence of abortions and menorrhagia, and that cirrhosis and absolute sterility seem the most favourable termination to be looked for. But it is an assumption fairly supported by experience that while the ovaritis is not far advanced, abortion is due rather to the adhesions than to the diseased state of the ovum. Now there is a short way of dealing with this class of cases, and with painful prolapse, even when unaccompanied by the annoyance and danger of frequent miscarriages, which is well known to you. I have performed the operation of removal of the uterine appendages many times with very satisfactory results, and when the tubes are distended, their uterine orifices strictured, and their fimbriated extremities occluded, there is no other method of treatment worthy of regard. The value of this operation in pyosalpinx, pelvic hæmatocele, and other diseased states of the tubes, cannot be over-estimated, and I think Mr. Tait has not received due praise from the medical profession for his powerful advocacy of it. But I cannot admit his argument that the attempt to distinguish the different varieties of chronic inflammatory diseases of the uterine appendages is illogical and impossible (*vide* 'General Summary of Conclusions, &c.' p. 18, 1884). This is to compress pathology out of all recognition, and suggests, what he never meant, that the treatment of all varieties must be similar. But I have many times refused, and I suppose other surgeons have refused, to perform this operation upon young women with pelvic trouble,

because no mass could be felt behind the uterus and no distended tubes at its sides. It is no deprivation to remove the ovaries when there is abscess, when they are riddled with cysts or pultaceous, but when there is healthy structure left, it seems somewhat ruthless to take away all chance of child-bearing. Pathology, like surgery, must be sober and should distinguish. It is alleged that the diagnosis is beyond our power. But the pelvis can be more thoroughly explored than, for example, the thorax, and it is chiefly when there is no gross pathology, when there is much pain yet little to be felt, that diagnosis is difficult. Young women are sent to us with a long history of pelvic pain dating from a chill during a menstrual period, a gonorrhœal inflammation, or an accidental abortion. On examination the ovaries are prolapsed and very tender, but nothing more can be found, or the ovaries are adherent as well as prolapsed, and the uterus is, perhaps, retroflexed and cannot be replaced. If the patient is anæmic, reasonable measures against this state are tried unless they have been tried already, and if there is disease of the cervix uteri it is treated. When these measures fail, as they very often do, and when pessaries prove useless, as they almost always do, some advise you to give up further attempts at cure, and some advise you to remove the uterine appendages. I have tried both methods frequently, and am satisfied with neither. If you remove the appendages you generally, though not invariably, relieve the suffering; there is no question as to that; but then you have sacrificed the power of reproduction. When a woman has had several children and is approaching or past forty, to remove the prolapsed ovaries is perhaps the best practice, but in young women I have abandoned it, and, when the symptoms are so inveterate as to require surgical treatment, I perform a suspensory operation instead of excision, oöphorraphy in place of oöphorectomy. In the virgin the ovaries slope inwards, forwards, and downwards, and are suspended by the so-called infundibulo-pelvic ligaments or peritoneal folds of broad ligament stretching from the pelvic brim to the

infundibula of the Fallopian tubes, and containing the ovarian vessels. But after childbirth these folds are relaxed and the ovaries are suspended by the utero-ovarian ligaments, which are dense fibro-muscular cords. When this relaxation of the infundibulo-pelvic ligaments is exaggerated, which may happen without previous childbirth, the ovaries hang vertically downwards and are prolapsed whether the uterus is retroflexed or anteverted. By the suture of the hilus of the ovaries to the relaxed infundibulo-pelvic ligaments near the brim, the vaginal position of the ovaries is restored, the Fallopian tubes fold over them as before. This is oöphorraphy.

Several times when I have hoped to perform only oöphorraphy I have been obliged, finding the tubes diseased, to remove the uterine appendages, but in the following fourteen cases the suspensory and conservative operation seemed sufficient.

1. T. B., aged 18, single; menstruation commenced at 14, but when 16 years old the menstrual periods ceased after a chill for four months. Since then it has been profuse and irregular, recurring at least every fortnight, occasionally five times in a month, and always accompanied with pain; ovaries prolapsed and painful when touched, uterus anteflexed. Concluding from former experience that local treatment of the anteflexion would be a long affair and probably unsatisfactory in the end, I performed oöphorraphy on July 1. When she left hospital the uterus remained anteflexed, but for the last three months she has been in service, her monthly periods are now regular, and she has no complaint or pain of any kind.

2. M. O., a married woman, aged 21, with two children, came into hospital very ill and haggard, and with a temperature of 103°. There was extreme pelvic tenderness, for months she had been unable to look after her house and children, and, lately, wearied of her ill-health, her husband had deserted her. The ovaries were prolapsed and adherent, and there was effusion of fluid into the peritoneum. On July

6, during laparotomy, much serous effusion was sponged out of the pelvis. When the ovaries were freed from their adhesions in Douglas' space and drawn out of the abdominal incision they seemed fairly healthy, and, as the tubes were pervious, instead of removing the appendages, as I had intended, the ovaries were stitched by a single fine ligature to the outer fold of the broad ligament beyond the Fallopian tubes. She made an excellent recovery, and left hospital without a trace of pelvic pain or discomfort, and, though with some difficulty, a reconciliation was effected between husband and wife. Unfortunately she returned with a recent attack of gonorrhœal urethritis in the beginning of September, and she is now, or was lately, under treatment for that complaint in Sir Patrick Dun's Hospital, under the care of Dr. Kirkpatrick.

3. M. M., single, aged 23; with constant back-ache, bearing down pains, and sickness, irregular, profuse, and painful menstruation, anteflexed retort-shaped uterus, tender, prolapsed ovaries, and a history of acute rheumatism a month previously, the diagnosis of which, however, seems doubtful. She had been a domestic servant, but was quite unfit for any employment, and the therapeutic stores of the hospital had been exhausted upon her without benefit. July 8, oöphorraphy, the infundibulo-pelvic ligaments being unusually long, the operation proved a very easy one. Neither immediately after operation nor afterwards was the anteflexion diminished, but her symptoms have certainly disappeared, and she is now in service.

4. A lady, aged 34, twice married, no children, whose illness came on after prolonged and anxious nursing of her first husband, and had lasted over two years. Since her second marriage, eight months previously, she had been unable to walk about, and had lost all appetite. The ovaries were prolapsed, there was serous effusion, and she had been advised to have her uterine appendages removed by an obstetric physician. She was, however, very averse to this, and on August 6 I performed oöphorraphy and sponged out

the effusion. When the left ovary had been suspended the right one had become sufficiently elevated, and it was not interfered with. Both ovaries consisted chiefly of thick-walled shrivelled cyst walls or husks, and I fear the chance of pregnancy is small, but her pain is all gone. When I called upon her last week with a view to recording her case, I found her busy at house-cleaning, her servants having suddenly left her.

5. M. B., aged 38; six children, ovaries prolapsed and adherent behind a painful retroflexed uterus. Her paroxysms of pain, which kept her sometimes for three weeks in bed, were at first ascribed by her physician to renal calculi, but as no stone ever passed the uterus and there was no gravel in the urine this theory was given up. She had consulted several physicians, by one of whom she was advised to have her uterine appendages removed. On August 27 I made an abdominal section, freed the uterus from the sacrum, and the ovaries from Douglas' space. As the ovaries did not appear to be diseased, they were not removed, but stitched by their capsules to the infundibulo-pelvic ligaments. I was aware at the time that I had not stitched them so near the pelvic brim as usual, and now, though the ovaries are sufficiently suspended to prevent any return of paroxysmal pain, and she considers herself cured, there is still some retroflexion of the uterus.

6. C. E., aged 23; two still-born children, menstruation regular but painful, constant back-ache, and for two hours after rising the pain is always so severe, especially in the left groin, that, though a poor woman with a house to look after, she is obliged to stay sometimes for a fortnight in bed. The uterus was retroverted and the ovaries prolapsed and freely moveable. As she was very anxious that something should be tried, I performed oöphorraphy on August 28 with the happiest results, for both uterus and ovaries are now in their normal position, and she is entirely free from pain.

7. M. A. F., aged 23, with one child three years old; after this confinement she became menorrhagic, and for several

months she had scarcely been free from menstrual flow; occasionally it flowed in clots, but in general it was not so profuse. On vaginal examination nothing more could be found than prolapsed ovaries, and as she was very anæmic and ergot was quite powerless, oöphorraphy was performed on September 3. It is, of course, too soon to state final results, but when I saw her on October 26 her menstrual flow had just ceased after continuing for only three days. I can only hope that she will maintain her present healthy condition.

The remaining cases are so recent that I only allude to them in illustration of the class of cases which this operation seems likely to benefit.

8. M. U., a young married woman, a patient of Dr. Mulliner, with prolapsed ovaries, cervical discharge, and pain in back and groins; laparotomy on September 28. The left ovary contained a blood cyst which burst and bled so much that it was removed; the right ovary was suspended by oöphorraphy. She has now lost all pain, and the vaginal discharge has entirely ceased.

9. E. B., single, aged 26; had a child when only fifteen years old, and since then has been ill with pelvic pain and unfit for constant employment; uterus completely retroverted and ovaries prolapsed. As she had already been treated with pessaries and otherwise in a special hospital of a neighbouring town, and as she had been kept for a long time in several convalescent institutions without much benefit, I performed oöphorraphy on October 1. She went back to Southport on October 26, and when Dr. George Wood, of that town, who sent her to me, examines her, he will find the uterus in its normal position, the ovaries out of the way, and the patient fit for service.

More recently still I have performed oöphorraphy on five patients, aged respectively 28, 23, 30, 24, and 22, in all of whom the ovaries prolapsed and adherent. In all the uterus is now straight, and the ovaries are suspended as they were before childbirth; they have all recovered from the operation, and are in the meantime cured of their pains.

The operation is an easy one for those who are familiar with abdominal surgery. A median abdominal incision, large enough to admit two fingers, is made. When there are uterine and ovarian adhesions they are separated, and one ovary is drawn out at the incision. The infundibulo-pelvic ligament is thereby put upon the stretch, and, after a small sponge has been placed on each side of it, a small curved needle threaded with fine catgut is passed by means of a holder through its posterior fold near the pelvic brim, and the needle and thread are then passed through the hilus of the ovary, so that when the ovary is returned into the pelvis and the ligature is tightened and tied, the ovary lies easily in its normal situation, and only the knot of the ligature is visible. It should be remembered that while the ovary is held outside the abdomen it is inverted. A single knot having been tied and tightened so that no loop of intestine can possibly be included, the ovary is returned into the pelvis, and the ligature is again gently tightened and secured by a second knot. While suspending the second ovary care should be taken that no strain is put upon the broad ligament, else the ligatures might give way. How long it is until the single ligature on each side is absorbed I do not know, certainly not until long after adhesions have firmly fixed the ovaries in position. My cases seem to show that while retroflexion of the uterus is cured by this operation, anteversion and anteflexion are not, but that the pain and discomfort in the forward flexions are sometimes entirely ovarian. As regards the main purpose of the operation, the relief of pain by suspension of prolapsed ovaries, the results have so far been very satisfactory. Had the operation been in the region of sacrificial surgery I should have waited longer before bringing it under the notice of this Society, but being conservative and applicable in many cases where other methods of relief short of excision fail, I place this preliminary report before you.

Dr. BARNES wished to draw attention to the fact that although it was usual to speak of prolapse of the ovaries, it was commonly only one ovary that was concerned—and this was the left. He (Dr. Barnes) had made the observation

some years ago, that Douglas' pouch was much deeper on the left side than on the right. This he had ascertained by repeated clinical observation, and subsequently verified by examination in the dead-house, by taking casts and measurements. This anatomical condition accounted for the fact that hæmatoceles and similar collections were commonly most marked in the left side. They were rarely median or right-sided. Again, in association with this form of Douglas' pouch, it was found that the right ovary was braced up by shorter ligaments, so that it was much less liable to fall, whilst the left ovary, being suspended by longer ligaments, was more moveable, and much more disposed to sink behind the uterus. Hence prolapse of the left ovary was sometimes associated with retroflexion of the uterus; as he once saw in a striking case at St. George's, where, having removed the right ovary for cystic tumour, and searching for the left ovary to inspect its condition, he found it pinched up by the retroflected uterus in Douglas' pouch; it exhibited an early stage of cystic disease, and was therefore also removed. The case did well.

Mr. LAWSON TAIT could only say that where there was really chronic inflammatory disease of the ovary no such operation could be expected to be successful. Although the details of the operation seemed to him to be original, the idea was one which Mr. Tait had entertained and carried out in another way five or six years ago. His operation consisted of puckering up pieces of the broad ligaments in a ligature, shortening the ligaments therefore in all their diameters. This had the effect of bringing the inflamed organ up to a higher level, but it absolutely failed in giving the patient the relief desired. He could only say that Dr. Imlach's proposal was one which would have to be judged upon statements of the cases two or three years after the proceedings had been carried out. His own experience was that if an ovary were inflamed and adherent the disease was practically incurable save by removal. This was specially the case in the lower ranks of life.

Dr. BANTOCK hoped his observations would not be taken

as indicating a desire to throw cold water on the operation described by Dr. Imlach because of its novelty, but he could not refrain from entering a mild protest against the frequency with which he appeared to perform it, for he felt that Dr. Imlach had not demonstrated the necessity for it. He was particularly struck by one of the cases mentioned by Dr. Imlach in which there was retroflexion of the uterus along with the prolapsus of the ovaries. These were the cases in which he thought the operation was least justifiable, if at all, for it was well known that the ovaries were dragged down by the uterus, and that the replacing of the uterus usually restored the ovaries to their normal position also. Such cases were within his own knowledge. Dr. Imlach was inclined to throw discredit on the pessary. Now there could be no doubt that pessaries were very much abused, both in the sense of being maligned and misused, through the ignorance of practitioners who would not master the principles underlying their use. A patient seeks advice complaining of discomfort in the pelvic region, and the practitioner at once proceeds to adapt, or rather *insert*, a pessary, without anything but the most cursory examination. Now, the first essential for the proper use of a pessary was a correct diagnosis, and a pessary ought not to be introduced until the practitioner has satisfied himself by careful examination that the uterus alone is at fault. He contended that it was not so very difficult to make this diagnosis, and to ascertain that the trouble was due to the condition of the uterus itself rather than the appendages. It may be, and indeed is, very difficult to say whether a given case is one of pyo-salpinx, of hydro-salpinx, of hæmato-salpinx, or merely enlargement of the tubes and adhesion of the ovary—and it may be enlargement—from chronic salpingitis and ovaritis, but it ought not to be, and is not, so difficult to separate an affection of the uterus from that of the appendages. He was very much afraid that, stimulated by the remarkable success of Mr. Lawson Tait, it was becoming too much a *fashion* to open the abdomen and remove the appendages without rhyme or reason. If the ovaries—and it

even more especially applied to the appendages—were diseased, he quite agreed with Mr. Tait that the only thing to do, in order to relieve the patient of her symptoms, was to remove them. He knew of no remedies which had the slightest effect on a diseased ovary or tube. But when the ovaries were healthy, as in some of the cases described by Dr. Imlach, he did not think this operation was the proper mode of treating any symptoms that might be present, and that it was not justifiable to open the abdomen so frequently as had been done by Dr. Imlach. It was true, and it was a comfort to find, that Dr. Imlach had been very fortunate in escaping any untoward results, but this was only because he was a skilful operator. He trusted that young surgeons would not be tempted by these fortunate results to follow in his footsteps, for he thought Dr. Imlach was far from proving his case. He had been led to make these remarks by some cases which had come under his observation. Two were of the most striking character. The first was that of a single lady, aged 26, who had been an invalid for many years, in spite of a great variety of treatment, both local and constitutional. Previous to consulting him she had been doomed by an eminent obstetrician to the loss of her uterine appendages. The result of a careful examination was that the patient's appendages were probably healthy, but that she was suffering from a bad retroflexion. It was one of those cases in which a vaginal pessary (of which she had already worn several varieties) could be of no service to her, and which could only be relieved by the instrument which goes by the name of our President. The first menstrual period after the introduction of the instrument was so satisfactory that the patient said she had not been so free from pain for seven years. She was then able to walk about fairly well, and was unconscious of the presence of the instrument. When he last saw her—at the beginning of October—after an interval of about six weeks, and three months after the introduction of the instrument, she had gained 5 lbs. in weight, and menstruation was painless.

The second case was that of a servant girl, aged about 22, who had been in a suburban hospital for three months, suffering from constant pain, for which she had been treated freely with blisters, poultices, subcutaneous injection of morphia, &c., without the slightest benefit, and who had been sent to me to have her ovaries removed. As in the former case, a careful examination failed to reveal anything but a very acute anteflexion of the uterus, and I at once put in a Meadows' compound stem. No medical treatment whatever was employed. In two days the patient was out of bed quite free from pain, and within the week she went home. She is now in a situation and in perfect health.

These two cases—and they were not the only ones he could quote—justified him in uttering a note of warning against the indiscriminate removal of the uterine appendages, and the much too frequent performance of abdominal section. He thought Mr. Tait owed it to himself to try to keep within reasonable bounds the zeal of our young surgeons, and to put a stop to this reckless practice.

He was told a few months ago by Dr. Emmet that it was no uncommon thing in New York to see a soup-plateful of uterine appendages presented by some of the younger surgeons to some of the societies there. Discredit was certain to fall upon a most important advance in our art, which we owe to the genius and skill of Mr. Lawson Tait, if such zeal were not discountenanced and condemned, and he trusted his note of warning would not be uttered in vain.

Dr. IMLACH, in reply, said that Dr. Bantock had somewhat mistaken the object of his paper; it was to promote conservative in the place of sacrificial surgery, and Dr. Bantock would probably think more favourably of his method when he read it. He repeated that when the tubes were diseased oöphorraphy would be useless, but when they were healthy, when there was much prolapse of the ovary, some ovaritis, and a great deal of pain, there was a condition which all the old books called hopeless, and for which nearly all the new advised removal of the uterine appendages. He main-

tained, from his experience of fourteen cases, that if the ovaries were slung up the pain ceased, and the chance of child-bearing was left. In these cases he told patients that he thought the tubes were healthy, but could not be certain until he had seen them, and that if they were diseased they would be removed. He quite agreed with Mr. Tait that for a final judgment of the value of the operation a longer time should be allowed to elapse. He was waiting, and had only professed to give a preliminary report. Removal of prolapsed ovaries was not invariably successful. He had experienced one complete failure and one partial failure. In each of these he had only removed one ovary and tube at first, but had subsequently removed the other ovary and tube without much success. Still, in other cases, the successful relief of pain had been marked, and doubtless in the failures there was some obscure renal affection which he could not understand. He thought the greater frequency of prolapse and disease of the left ovary, to which Dr. Barnes had alluded, was a fact, but that it was over-estimated rather than the reverse, owing to the position of the patient on her left side during examination. Both ovaries were generally prolapsed. He thanked the meeting for the courteous manner in which the members had treated his paper, and trusted they would give a trial to the operation when they had a suitable case which was incurable by medicine and rest.

The Society then adjourned.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, NOVEMBER 25, 1885.

DR. ALFRED MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 32 Fellows, 2 Visitors. The following were elected Fellows of the Society:—Dr. P. Budin, Paris; Mr. Alfred Cooper, F.R.C.S., London.

The following were proposed for election:—Dr. A. B. Tadlock, U.S.A.; Dr. Septimus Sunderland, London.

Dr. PURCELL showed the uterus removed from Maria G., aged 42, married, admitted to the Cancer Hospital, October 16, 1885. The mother of six children; is a thin, delicate woman, and has been losing flesh. In April last believed herself to be pregnant; in July had a flooding and had uterine bleeding a week prior to admission. These losses and her general wasting and delicate state of health were her sole reasons for seeking advice; no history of cancer in her family; father died at 70, and her mother died of heart disease.

On examination per vaginam an epitheliomatous growth was found occupying the posterior lip of the os and extending posteriorly on to the wall of the vagina, the uterus being freely moveable; no further infiltration of the disease discovered. Extirpation of the uterus per vaginam suggested itself as feasible, and it having been explained to the patient, she consented to submit to operation, hoping that all the disease would be removed. October 20 she was placed on the table and anæsthetised, the diseased os was brought into view by speculi and drawn down by means of a hook fixed into the anterior sound lip, an incision was made through the

mucous membrane of the neck of the uterus well above the disease by means of a knife with a short blade at right angles to the shank. The mucous membrane was now dissected upwards off the neck by scalpel and point of the finger, performing a process of enucleation of the organ. As the mucous membrane was freed the edges were at intervening distances grasped by Wells' compression forceps until the entire circumference was held; the finger made its way gradually upwards until it was passing over the fundus and feeling the large supplying artery pulsating beneath it; here one of my assistants, to help to bring down the uterus, grasped it anteriorly with a vulsellum forceps, part gave way, and some water began to trickle down. The accident—namely, a tear into the bladder—was recognised, and attention was at one directed to rectify the misadventure; the index finger was passed into the cavity of the bladder and a double rent exposed; these two rents were closed by seven silver wire sutures passed through the muscular coat but not allowed to pass through the mucous membrane of the bladder; the aperture was closed in somewhat the shape of the letter T. After this *contretemps* a few touches of the knife through the subcellular tissue freed the bladder out of the way. Now, knowing how intimately the peritoneum is connected with the fundus of the uterus, in place of attempting to completely enucleate the organ, a wire écraseur was passed round, and by its means the uterus was amputated, the cavity was plugged with two iron tampons (cotton wool with string end soaked in liq. ferri perchloridi), and these were kept up by three dry wool ones. The walls of the vagina were laid in position, a self-retaining catheter passed into the bladder, and a half-grain morphia suppository passed per rectum. No hæmorrhage of any account troubled.

The following day the report says the catheter fell out during the night; the draw-sheet was found wet; the house surgeon drew off half a pint of urine; the tampons were all removed from vagina, being assisted in their withdrawal by having carbolic oil syringed well up the vagina. A vaginal

drain-tube was then inserted and connected with a basin beneath the bed, as also the catheter in the bladder into a separate basin; parts were freely dusted with iodoform crystals.

Oct. 22.—Draw-sheet was dry, 15 oz. of urine drained away, and about 2 oz. of dark catamenial-looking discharge per vaginal tube. Parts were syringed out with iodine water 3j to Oj, as also was the bladder.

Oct. 23.—Sheet found wet; house surgeon drew off 5 oz of urine and 8 oz. had dribbled through the tube.

Oct. 24.—Draw-sheet found wet; 19 oz. of urine drained away through tube.

Oct. 25—Draw-sheet wet; catheter had escaped out twice; urine saved, 25 oz.

Oct. 26.—Draw-sheet dry; urine saved, 27 oz.

Oct. 27.—Dry; bowels moved during night; urine, 25 oz.

Oct. 28.—Patient was to-day moved from the Special to the General Ward. Urine saved, 26 oz.; specific gravity 1025, with a muco-purulent deposit.

Nov. 1.—Bladder holds; 38 oz. of urine saved; has a copious deposit; to have the bladder syringed out with sol. of quinine, 2 gr. to Oj.

Nov. 2.—Catheter wholly removed; patient passes water; no pain; spirits good; sleeps and eats well.

Nov. 20.—Examined; the vagina is found to be a *cul-de-sac*; the wire sutures remain in position. Patient begs she may not be touched till after Christmas; she takes her discharge with them left in; urine clear and normal.

Temperature, the night after the operation, rose to 99·6°; next day fell to normal, to rise in the afternoon to 100·2°—the highest point to which it reached; the third day varied between 99° and 100°; fourth day, between 99° and 99·6°; fifth day, fell to 96·8°, evening 99°; sixth day, 97·8° down to 96·6°; seventh day, between 97·2° and 98·6°; from this it ranged about normal.

The specimen shows that the disease includes the posterior lip of the os and neck of the uterus and on to the vaginal wall; a healthy margin surrounds the growth, a probe passed

through the os measures a depth of 2¼ inches. The plane through the body of the uterus marks the use of the wire écraseur. The growth is epitheliomatous.

Dr. PURCELL was anxious to know from the Fellows of the Gynæcological Society whether the uterus could be enucleated and detached away from the peritoneum above, which, if a fact, it would be a means of removing the entire uterus without entering the cavity of the peritoneum, and make a new departure in operations on the uterus for malignant disease, granting that the uterus be freely moveable and the disease localised to the uterus.

Dr. EDIS thought that unless in cases where the diagnosis was made at a very early date, there was almost a certainty of recurrence of the disease within a twelvemonth or so after the operation. The pain then was of a greatly aggravated nature, much worse than had nothing been done.

In one case Dr. Edis operated upon, by the supra-vaginal excision, the patient was free from recurrence for seven years, when she succumbed with well-marked infiltration of the pelvic organs.

Dr. WALTER showed a peculiar form of uterine polypus removed a few weeks ago from a married woman, aged 22, who had never been pregnant.

It grew from the mucous membrane just within the external os, and resembled a mass of hydatid or vesicular disease of the chorion.

It weighed half a pound, but the cysts, when placed in weak spirit and water, soon lost their contents (nearly pure blood), and contracted into a number of solid floating masses, most of which were pedunculated.

The disease was now returning in a modified form in the cervix uteri, and Dr. Walter promised to report the case more fully at some future time. He regarded the specimen as one of papilloma—cystic in variety, and epitheliomatous in character.

The PRESIDENT drew the attention of the Fellows to the almost unique nature of the specimen shown by Dr. Walter.

Dr. EDIS suggested that specimens of this nature retained their original characteristic appearance much longer and better when preserved in a solution consisting of glyc. ac. carbol. ℥ss, glyc. pur. ℥iij, spir. methyl. ℥ij, aquam ad Oj.

Mr. LAWSON TAIT said that with regard to Mr. Walter's specimen, he had never seen anything like it before. There could be little doubt that it consisted merely of an enormous exaggeration of the villous structures of the mucous surface of the cervix, and in that condition its character approached the malignant, and its subsequent history completely justified this view.

Dr. BARNES, inspecting the specimen, might say at once that it could not be mistaken for hydatiform placenta. In this disease vesicle generated vesicle, but in the specimen shown the terminal enlargements or vesicles were each supported on a long pedicle. It suggested rather the condition which he had described and figured as the 'hypertrophic polypus,' the result of an outgrowth of the cervical villi and glands. The case was very remarkable, and ought to be preserved and figured.

Dr. AVELING exhibited an ovarian cyst which had ruptured during examination. It was at once removed, and the temperature, which before the operation had been between 100° and 102°, went down directly after to normal and remained there. The specimen also showed chronic salpingitis and a cheesy deposit in the tube.

Mr. LAWSON TAIT exhibited a new form of continuous cautery which he had originally devised in a less complete and perfect form some years ago, assisted by Messrs. Krohne & Seseman. The advent of Paquelin's cautery had put an end to his efforts to complete it, because that instrument seemed to meet every possible requirement. It had, however, the disadvantage of being extremely uncertain in its action and very liable to get out of order, specially apt to be out of order exactly when it was wanted. This Mr. Tait found to be due to the fact that the fine apertures of the inner tubes were blocked by the resinous deposit of the benzine oil, and if the

slightest drop of oil got to any part of the cautery points its action was almost entirely and at once destroyed. The form of cautery which he now exhibited was what he proposed to use for dealing with uterine pedicles in uterine hysterectomies, and was of a rougher, much larger, and much more formidable appearance than the instrument would be when devised for smaller operations. It consisted of a capsule with a circular cone for the purpose of securing the return out draught. Against the inside of the capsule was directed a stream of gas urged forwards by an air bellows, so that as soon as the capsule became heated the bellows were brought into action and made to play upon the flame against the inside of the cone, raising it to any temperature desired.

Dr. EDWARD BLAKE agreed that it was important to have the right kind of benzoline in order to secure the good services of that fickle friend to the surgeon, Paquelin's thermo-cautery. It should be remembered that the cheaper or inferior forms of spirit are best because they are highly volatile.

But to cut down the chances of failure to a minimum it is equally necessary to recollect that, in cold weather especially, the whole apparatus must be well warmed.

It is as well to keep the tap of the benzoline bottle screwed down during the heating process to avoid the awkwardness of an explosion.

Dr. BANTOCK exhibited two cysts which he had removed in the afternoon from a patient aged 50. About eight years ago Dr. Wynn Williams had removed a tumour of the breast by means of bromine. The disease returned in the axillary glands, and these were removed by the knife, and a number of nodules were excised from the region of the breast at intervals, with the result that the disease seemed to have been completely eradicated. Five years ago she began to complain of pelvic discomfort, and latterly it had increased so much that she was anxious for relief. An accurate diagnosis was impossible; palpation of the abdomen was difficult owing to the abundance of fat in the parietes, and, per vaginam, the uterus was found to be intimately connected with a mass

which filled the pelvis. The larger cyst, which contained five pints, was enucleated from the left broad ligament, the smaller one, containing about a pint and a half, from the right side. Attached to the latter is the right Fallopian tube in a dropsical condition. Both cysts are evidently parovarian, the contents being of low specific gravity and not coagulating on heating. There was considerable oozing from the raw surfaces; the pelvic cavity was well washed out with warm water, and a drainage tube inserted.

Laceration of the Cervix Uteri. By RICHARD T. SMITH, M.D., M.R.C.P. London.

About five years ago my attention was first directed to this subject by a few cases that were related to the British Medical Association at its autumnal meeting. Having in the interval performed in more than fifty cases the operation recommended by Emmet for the cure of the laceration, and having bestowed a considerable amount of careful observation on the general bearings of this condition of the uterus, I hope to call forth from this Society a more thorough, exact, and authoritative expression of opinion as to the value of Emmet's teaching and practice than as yet has been given in England. This paper is chiefly an exposition of his views; by your kind permission I may give a subsequent one on the details and varieties of the condition and the operation.

No wonder our American friends express their surprise at the scanty attention which British Gynæcological surgeons have devoted to teaching, and to a mode of treatment which to them has long since passed into a universally recognised rule of action. It is to myself a source of deep regret that for several years I should have been so blind to the true nature of some of the most intractable and most painful of uterine ailments. But I have the comfort, miserable as it is, of knowing I was not alone. In the first edition of Dr. Barnes's 'Diseases of Women,' in Dr. Athill's book, in the capital chapter on uterine surgery in Erichsen's system, and in

the late Sir J. Simpson's works—and even in Dr. Courty's book of 1882, while we find admirable descriptions of partial hypertrophies, of so-called ulceration, of a wide gaping os, of everted labia uteri—there is not a single surmise expressed that *the tear* in the womb is the head and front of the offence. Dr. Barnes graphically indicates the importance of laceration as a cause of puerperal mischief; but we have, I fear, failed to see in this condition the essential cause of chronic uterine disorders, of protracted discharges, of peri-uterine inflammation, and of various and serious nervous disorders.

In fact, nothing has surprised me so much in studying this subject and reading various authors' accounts of the diseases in which this condition of patulousness is universally recognised as a factor, as the absolute novelty of the explanation now set forth, for I must candidly admit that in my judgment the stage of hypothesis has long since passed. It is a clear ray of light; it is emphatically the explanation, and, once admitted, revolutionises whole chapters of description and equally modifies the methods of treatment.

While greatly satisfied with results, there are many points which still require elucidation; as the suitability of cases; what degree of laceration calls for the plastic operation; should it be done in mid-life while the possibilities of more conceptions exist; how far is it true that it predisposes to cancer, and should it be done to prevent such disease.

But for the present we desire impartial observation rather than earnest advocacy.

Now, to judge of the truth of the assertion (taking Dr. Pallen's word) 'that the sundering of the cervical tissue is the cause of all the ailment,' and to judge of the utility and success of the treatment recommended, it will be necessary to refer to the various forms of disease in which it is said to play so important a part. Another question also must be answered. Is this patulous condition of the os, which some seem to consider so trivial, ever physiological and a necessary sequel of labour, or is it not always pathological and indicative of the fact that a diseased condition obtains? I have very frequently

called the student's attention to the fact that in multiparæ no trace of labour can be seen in the uterus beyond a slightly increased diameter of the os uteri, accompanied, as a rule, with some flattening of the edges, and not unfrequently with the roundness characteristic of the virgin os remaining. Not many weeks ago I saw a lady who had had fifteen children, all easy confinements, and the os uteri did not exceed one-third of an inch in width, and the cervix was perfectly uniform and smooth. So true is this position that I need hardly remind you that in a famous medico-legal case a few years back, where to establish the fact of a uterus having borne children was of the first importance, it was accepted in the Obstetrical Society as an axiom, that absolute reliance could not be placed on the condition of the cervix and os; the sure sign of delivery must be sought elsewhere. Again, a virgin uterus long the subject of catarrh will often present a swollen cervix and some degree of flattening of the edges of the os uteri.

We may therefore assert pretty safely that the parturient act, when normally and healthily accomplished, is unaccompanied by the rupture of a single fibre in the genital tract.

That in the great majority of confinements it is otherwise no one doubts. Bennett, Simpson, Coghill, Barnes, Tilt, Emmet, Pallen, &c., are all at one on this point, and the difference in opinion and judgment only begins as the lacerations and accompanying phenomena are considered in the relation of cause and effect.

(I need hardly say that we are compelled to exclude from this paper the consideration of laceration of the cervix in its obstetrical aspect, i.e. its causes and consequences during the puerperal epoch.)

Sir James Simpson lays down the following propositions:

(1) Lacerations of the cervix, to a small extent, are very common, and much more common than is generally supposed.

(2) They are not necessarily the result of mismanagement, but occur in spite of all modifications of management; and also when children are born without any interference whatever.

(3) Slight lacerations of the edges of the os, and of the mucous and middle coats of the cervix, are found in autopsies after natural labours, and particularly in primiparæ.

(4) Proof is found in the irregularities in the shape of the cervix, in the cicatrices and contractions which are found radiating from the cervix into the vaginal walls.

The chief diseases in which the value and bearing of this sign have to be estimated are: Subinvolution; various local hypertrophies affecting the cervix, either as whole or in either of its segments; and diseases known as chronic inflammations with exudation.

(1.) *Subinvolution.*—While in the normal state the uterus will, in the course of four to six weeks, decline in weight from 1½ lb. to 2 oz. or 3 oz., and resume almost its previous size. In this disease we find, months after confinement, or even as late as two years, the organ excessive in bulk, with a patulous canal so open as sometimes to admit the finger. The cavity of the body is equally dilated, and the walls are not in contact. The lips are swollen out in lobes, which are separated by the scars resulting from the slight rents during labour. The os is soft and flabby, with abrasions of the epithelium, sometimes very extensive.

This, omitting mere symptoms, is a quotation from an eminent English author, and the causes of the condition are enumerated as accidental fevers, flooding during labour, perimetric inflammation, displacements, arrest of lactation, wilful or the result of lesions, &c.

Now Emmet states that for many years he has met with few or no cases of subinvolution that were not due to laceration. I have treated many, and have found that by intra-uterine applications, the use of quinine and strychnia, they have rapidly improved. In others of long duration and most obstinate to ordinary means, the repair of the cervical tear has quickly wrought a cure.

But the subject demands a more minute analysis.

What is the pathology of this big uterus? The causes enumerated may be predisposing, but they do not explain it.

The uterus, as a whole, is enlarged and tumid—sometimes pallid (i.e. in chronic cases), sometimes gorged with blood, in recent cases.

Around the os is an area varying in size which is bared of its epithelium, and looks pulpy and granular by reason of the projecting red, angry-looking villi of the mucous membrane, all bathed with viscid mucus. The cervical canal is in a similar position. Its rugæ are prominent and intensely vascular ; the surface easily bleeds on account of the thin layer of epithelium which covers the vessels. The canal is patulous.

What is this condition ?

Dr. Barnes says 'it is a combination of gangrene and ulceration. The first step is traumatic, the mucous membrane being killed by the bruising it underwent and by its partial severance from the deeper textures. It is remarkable that the area of epithelial demarcation is always limited. There is a more or less indented line of demarcation where the epithelium stops abruptly at a distance of about half an inch from the os. This line actually represents the extent of the mucous membrane which fell under the crushing. The fissures seldom or never go beyond.' What can be plainer ? He goes on to say : 'The process is one of repair ; the easily bleeding surface is trying to heal, and it may take weeks or months to recover its normal investment of epithelium.' But all this time another process is going on, for from the gorged vessels exudation is being poured out, and he quotes from an article on inflammation in Druitt's book : 'Exudations cannot remain dormant ;' they develop or degenerate, and in this case the tendency is to develop, and the consequence is hyperplasia and hypertrophy. The cervix becomes enlarged with fibrous tissue elements ; the cervix becomes dense, and elongates in various directions.

We are thus led to the very heart of the question. It is not a dispute about words ; far from it. One says it is ulceration, another says it is inflammation. Dr. Emmet and his coadjutors say it is a wound ; it is a lacerated wound —a sundering of tissues. And I entirely agree with them.

In the early stages it is a wound trying to heal by granulations; in the later stages it is a wound that has healed in an unfortunate manner, its opposing surfaces having become covered with cicatricial tissue. The pathology of the healing of wounds clears away the mist that has so long enveloped this subject, and the surgeon's skill in dealing with wounds will bring the aid that is needed. When we recognise the fact that union of a wound by granulation is identical with the process of repair of ulcers, we are not surprised at the conflict of opinion; but while no art is required to recognise a sore on the skin, it is not nearly so easy to distinguish exposed follicles and crypts and papillæ and mucous membrane granulations from ulcers. But surely the causation and treatment widely differ in the two cases.

Imagine for a moment a lacerated wound of the forearm left to itself—the edges dragged apart and irritated by the movements of the muscles, the surfaces covered with granulations and eventually healing with puckered scars; and all this is but a faint picture of a torn cervix, with its enormous blood supply and the irritations to which it is subject. As a rule antero-posterior lacerations heal well, but when lateral, and especially if on both sides and extending through the course of the cervix, a condition arises which defeats repair. By its mere weight the uterus tends to fall; by the impaction of the external surfaces of the labia against the vaginal wall the flaps separate through the rolling out of the tissues; the papillæ of the lining of the cervical canal are irritated and enlarged, constituting 'erosion,' and active hyperæmia of the whole organ is kept up. No doubt by rest and the use of a pessary, hot water, iodine, and other general measures, this erosion may be temporarily healed, but discontinue the treatment and every symptom will return, from the attrition of the surfaces of the tear and from the maceration of the same by the discharges, and especially if retroflex, which occurs in 80 per cent. of the cases, obtains. Moreover, the cervix is to the uterus what the spine is to the body, and by its restoration the tonicity of the uterus is vastly strengthened. Again, by

removing the scars and curing the erosion, the reflex irritability of the uterus is pacified, and the fluxion to the uterus and its appendages consequent thereupon is done away.

(IL) *Hypertrophy of the Uterus.*—Our inquiry is in respect of partial hypertrophy, and therefore the cases of general hypertrophy, where the whole of the uterus is equally involved and which occur in single people and in nulliparous married women, do not concern us, nor do the cases of elongation and stretching of the cervix where apparently the uterus may be five inches long. Of such I have seen two in single girls, æt. 19, and which in two or three weeks' time were restored to normal length by simple treatment.

Again, in flexions of the uterus, we find enlargement of one lip on the same aspect as the flexion.

I have suspended diagrams illustrating the cases under consideration, and by the authors they are all designated hypertrophy of the uterus. My contention is they are essentially cases of laceration.

The history is in reality a continuation of the same symptoms as already given of subinvolution, and is attributed by authors to persistence of the hyperæmia, congestion, and subacute inflammation of the cervix following labour. The so-called hypertrophy is therefore secondary, and may take months or years in its development. Some amount of cervicitis and endometritis almost always coexists, with dysmenorrhœa possibly, with menorrhagia very frequently. There is prolapse of the whole organ, and generally retroversion. Notice particularly the frequent mention of eversion of the labia, occasionally so extensive as to expose the palmæ plicatæ and ridges of the arbor vitæ, a condition which I maintain is a physical impossibility unless the cervix is torn. The tear is the cause, the hypertrophy is the natural sequence.

Now Dr. Barnes states distinctly that the first factor is arrested involution, and gives this order of development: hyperæmia, endometritis, interstitial fibrinous effusion affecting the cervix. The external tissues are to some extent fixed

by the bladder and fundus vaginæ, the innermost tissues, being soft, swollen, and gorged, bulge out at the os tincæ. And I wish to emphasise his observation that to the traumatic condition of the cervix during labour we must attribute the fact that the involution of the cervix is more disturbed than that of the fundus; hence arises a chronic subacute inflammatory process and hyperplasia which, if not ulceration, is distinguished by being bared of epithelium and covered with angry projecting villi. I must not pursue this line of thought any further. How this new growth is most active at the inner part of cervix, necessarily so, and causes eversion; how that the uterus, being congested, is heavy, and therefore causes descent; how this irritates the vulva, provoking straining efforts; how there is consequent prolapse, needs no description.

By numerous cases I can attest that by healing the tear all the other conditions will improve, and with a rapidity which is often most surprising. Take an illustration.

A patient, æt. 25 years; one child fifteen months ago. At the end of a month the uterus was prolapsed externally, and she came to me wearing a Zwanck; the uterus was 4½ inches long. The cervix was torn on both sides, and on the right there was evidence that originally the tear extended into the vaginal wall. Both labia were everted. Perineum also torn. In a month's time the uterus measured 2½ inches, and restoration was complete.

I may add that of the cases I have done three have had children subsequently, one having had two children, and in all the cervix remains intact to a great extent. The doctor of the one who has had two children writes: 'She had a good time. I was not with her more than an hour; the os dilated nicely, the placenta followed quickly, and she had no loss.'

In my own practice I have seen the genesis and results of three marked cases of laceration in primiparæ, but the cause was not a previous inflammatory rigidity.

My purpose to-night being chiefly to state Emmet's views and confirm them by observation, I will simply mention that while Dr. Bennett commends the Americans for

enforcing our attention to the frequency and importance of laceration, he insists that the lesion is really due to previous disease which caused rigidity of the cervix; consequent on that rigidity, the use of the hand or of forceps, or excessive rapidity of the labour, produces the tear. He attributes this rigidity to hypertrophy and induration, the result of erosion and inflammatory affections prior to labour. The answer to this position could only be found by careful observation of primiparæ. Nevertheless he admits that in chronic cases where there is a deep fissure and thick hard lobes which can be everted, the plastic operation is preferable to prolonged treatment by caustic potash, but in milder cases, by the use of NO_3AgI emollients, the hypertrophy softens, the edges become clean, and only a notch remains, and no operation is required. In this opinion he is in accord with many English physicians. It cannot be denied that the boundary line between a patulous os associated with cervicitis, endometritis, and some amount of erosion—and all this possibly I quite admit in single people and between milder cases of laceration—is not always so easy, and will form the line of battle in men's opinions on the subject. Yet my judgment is, given a laceration, repair it. It is not so simple a matter always to detect a laceration, but wherever the labia cervicis can be rolled inwards, that cervix is surely torn. But the scope of this paper scarcely allows any reference to the numerous and important details of the subject.

Another line of inquiry there is which to me greatly enhances the value of this method of cure. Compare it with the alternatives. (1) For safety, for quickness of cure, for good results, for permanence, it is infinitely preferable to the torture of caustic potash and vinegar. The destruction of the induration by caustics means, as a rule, three months in bed, with considerable risk of cellulitis; by trachelorrhaphy five or six weeks is ample. Think, also, how painful caustics are, even if Paquelin's cautery is used. I have done one case without anæsthetics, the patient complaining but little of pain, and I am informed this is a very frequent practice in

America. (2) Professor Martin, of Berlin, practically admits Emmet's teaching, for he amputates the cervix and then brings the edges of the mucous membrane together across the stump. (3) Then there is Thomas' plan of slicing off a superficial layer of the hypertrophied lips in the hope of causing atrophy of the remnant; e.g. tonsils. But these two are neither so rational nor effective.

And, lastly, we have the almost unanimous verdict of gynæcologists that while in the vast majority of cases where there is a large os and a tender granular mucous membrane, these can be toughened and apparently healed by rest, douching, caustics, &c., yet in a few weeks the patients are as bad as ever, so much so that an eminent writer has said, 'If no better in two months, let them alone and give up meddling.'

I can only say for myself, on the evidence of many cases, the repair of the laceration completely cures; the uterus lessens in bulk, flexions improve most notably, and the pain disappears.

Now beyond this series of uterine disorders marked by enlargement of the womb, by a gaping os, by erosions with copious, debilitating, intractable discharges, there lies a wide field for clinical observation in cases which could fairly be classified under the head of painful uterine diseases, and I am not sure that it is not to this field the new pathology will bring its richest boon.

The association of neuralgia and other neurosal affections with uterine disease is universally admitted; not only pain in the uterus and ovaries, but in various regions of the body. I should weary you by recapitulating them; headache, beating in the head, pruritus of the vulva, often severe pain in the eyes, and more particularly pain in the hip; one expressing it, 'pain like labour through the hips;' another, 'my hip aches so;' again, a central hypogastric pain with intolerable bearing down and gnawing pain in the pubic bone; occasionally there is the most exquisite tenderness of the cervix, and a vaginal examination or sexual intercourse will cause exhaustion and

faintness sometimes persisting for hours. Ovarian symptoms are wanting as a rule, except when there is concomitant inflammation of the pelvic structures and uterine appendages. Time forbids any reference to laceration of the cervix as a cause of chronic and recurring pelvic inflammation, but the question is brimful of interest.

As regards the menstrual flow we find in some a history, first of menorrhagia gradually lessening in degree and ending in persistent anæmia, while in other cases menstruation is protracted late in life and is associated with much suffering.

Now the explanation of all this suffering is said to be found in the fact that the wound has healed by granulation, a plug of dense cicatricial tissue filling up the gap, and consequently, as Emmet remarks, it is not simply the cases where the os remains wide and gaping, with tender nodules interspersed in it, that require surgical relief, but cases where the cervix may be comparatively smooth and uniform, but excessively sensitive. Every one must be familiar with the vast relief that is often conferred temporarily by leeching such cervices, by iodine, and by caustic. Let us, however, scrutinise the subject more closely. Consider that the tissue in the scar is hard and cicatricial, that the hypertrophy surrounding it and the use of caustics add another element of hardness, and the total mass may be hard as cartilage and in itself is almost bloodless; such dense blocks I have repeatedly shown to spectators. Now there are no lymphatics either in granulation tissue or in scars, so that all confidence in resolvents as being curative is misplaced; they do relieve any congestion that surrounds this block, but as the time approaches that by a law of nutrition the uterus should enter on a period of quiescence, here is a foreign body that defies all absorption and so becomes a source of irritation. By parity of reasoning we can understand how it is a source of pain. I have operated on several patients at ages ranging from 47 to 50, where there has been tenderness, menorrhagia, and various neuroses, with almost immediate and permanent relief Questions of most vital moment crowd around this

pathological position. What about cancer? While I cannot admit laceration by any means as the sole cause, I have been startled by the number of cases I have seen sprouting on everted labia, and with Dr. Goodell, of Philadelphia, I operate on all cases of laceration, if there is any family history of cancer. If there is any truth in the doctrine of irritation, here surely is a most conspicuous example—an ill-conditioned sore exposed to frequent irritation and varying blood-supply, and, as a rule, associated with a low condition of general health.

This paper is already too long, and it remains only to say that it is a fundamental rule that in neuralgia the cause of irritation must be sought and removed. And I can only commend this probable causation to all for careful observation and subsequent recording of their experience of treatment directed to this end, removing the cicatricial tissue and dense plug, thereby getting rid of a constant source of provocation.

Dr. BARNES could not help expressing his sense of the value of the interesting paper just read. It brought into more prominent notice a subject of great importance in its relations to metric and perimetric disorders. But he felt it necessary to protest against the name trachelorrhaphy, given he knew not by whom, to the operation. The term was arbitrary and incorrect. ὁ τράχηλος meant simply 'the neck,' and if it were applied to the neck of the uterus this must be specified. Thus we might describe it as 'hystero-trachelorrhaphy,' but 'trachelorrhaphy' simply was nonsense. It would be better to call it 'Emmet's operation.' Emmet's merit was twofold: first, he had devised an operation of great benefit to women the subjects of it, and, secondly, he had earned the gratitude of surgeons by endowing them with a new operation.

Dr. Smith had quoted from Dr. Barnes' First Edition, but in his Second Edition (1878) the operation was fairly described, and it was there stated that he had performed it. He believed, indeed, that he was the first to perform it in this country. He had done it at St.George's Hospital before 1878,

and had since practised it successfully in private. He wished to make some observations upon the illustrations which Dr. Smith had taken from his book. Dr. Barnes had drawn these cases as seen through the speculum, the blades of which, opening at the fundus of the vagina, separated and everted the split lips of the cervix. These would fall together again when the speculum was removed. The elongation or hypertrophy of the vaginal portion was no doubt partly due to hyperplasia kept up by the irritation to which the tissues were subjected; but there was another factor which was well illustrated by the drawing taken from a preparation in King's College Museum. This was a kind of strangulation. If the infra-vaginal portion of the cervix became from any cause engorged and hypertrophied, there was commonly induced a bearing-down force; the uterus then at the junction of the body and neck was more or less gripped by the supporting structures which surround it at that part, and which did also descend to keep pace with the descending uterus. The consequence was a kind of strangulation at the neck of the uterus, which tended strongly to increase the engorgement and hyperplasia of the part below the constriction. The preparation referred to showed this in a marked manner. A similar condition without splitting of the cervix occasionally occurred in single women. Thus he had seen enormous hypertrophic elongation of the infra-vaginal portion, even proceeding to protrusion beyond the vulva, where, being again gripped and strangled by the vulva, the projecting portion enlarged to the size of a Tangerine orange, completely blocking the vulva and suggesting the diagnosis of a polypus. He had quite recently amputated an outgrowth of this kind.

With regard to the cases calling for Emmet's operation. In the cases, and these were the most numerous, in which the splitting did not extend to the vaginal roof, it was generally enough to treat the hypertrophies and diseased lips by Paquelin's cautery. This induced a healthier action, and so promoted absorption that a cure might be confidently looked for. He had seen several cases of American ladies who had

been marked out for Emmet's operation whom he had quite cured by this mode of applying the cautery. But in cases in which the split extended to the very fundus or reflexion of the vaginal roof, and even a little beyond, so that the broad ligament was encroached upon, then the frequent risk of inflammation of the broad ligament and other mischief was great, and nothing short of restoration by Emmet's operation could be depended upon. A practical suggestion might be considered—namely, whether, instead of dissecting off the cicatricial tissue, a raw surface might not be better obtained by splitting, as in Tait's perineal operation.

He ventured to make one remark in explanation, if not in extenuation, of the comparatively greater skill in the treatment of vesico-vaginal fistula and split cervix in America than we had obtained in this country. He thought it was due to the simple fact that these lesions were much more frequent in America owing to the lack of skilled attendance upon women in labour. This was a circumstance conveying no reproach whatever against the teachers and qualified practitioners, but which was simply due to the more general deficiency of qualified assistants amongst large numbers of the American community. Then, again, the fame of the surgeons at New York and other centres attracted cases from all parts of the States, and this concentration of work led to the development of exceptional skill.

Dr. BANTOCK then proposed and Dr. Aveling seconded that the discussion on Dr. R. T. Smith's paper be adjourned until December 23. This was carried.

The Society then adjourned.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, DECEMBER 9, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 29 Fellows, 9 visitors. The following gentlemen were elected Fellows of the Society:—Dr. Tadlock, Dr. Sunderland.

The following gentlemen were proposed for election:—Dr. Charles James Cullingworth, Manchester; Dr. Thomas Harrison, London; Dr. James Adam Hopkins, Kansas, U.S.A.; Dr. Wilhelm Heiberg, Copenhagen; Dr. Woodruffe Daniel, Wareham; Dr. Francis William Nicol Haultain, Edinburgh.

Dr. THOMAS SAVAGE showed two specimens of hæmato-salpinx, successfully removed by abdominal section.

Dr. Savage also exhibited a large sacculated kidney, containing pus and several large calculi. It had been successfully removed by a vertical incision outside the rectus muscle, on the right side, the pedicle being transfixed with a pin and secured by a serre nœud.

Dr. EDIS exhibited a sacculated kidney which he had removed from a patient in the Chelsea Hospital for Women on November 30. She was admitted for severe intermittent pain in the right loin, hæmaturia, and pyouria. These symptoms had been present on and off for between two and three years. Her temperature ranged between 99° F. and 102° F. On examination, a distinct tumour was detected in the right lumbar region, lying partly under the liver and extending down nearly to the basis of the pelvis. After consultation

with his colleagues, Dr. Aveling and Dr. Fancourt Barnes, it was decided to remove the kidney by abdominal incision in preference to performing the lumbar operation, as the organ was so enlarged and apparently distended that its removal by this latter method was deemed impracticable. Ether having been administered, an incision, two inches above and two inches below the umbilicus in the median line, was made. The left kidney was then explored, and found to be apparently normal in size and consistency. The mesocolon being torn through with the finger, the enlarged right kidney was detached from its surroundings and brought out through the incision in the abdomen. It was found to be sacculated, the hilus and ureter being enormously distended. The ureter was first ligatured in two places and then divided between, so as to prevent any of the fluid escaping into the abdomen. Two stout silken ligatures were then applied securely to the renal vessels, and the pedicle divided between. No blood or fluid escaped into the peritoneal cavity. A careful toilette was made, and the wound in the abdomen stitched up with silk. The operation lasted under an hour.

On examining the kidney it was seen to be considerably enlarged, the surface smooth but irregular in outline, presenting several marked depressions and prominences. On section numerous saccules were seen, most of them wide-mouthed, and some approaching very near the surface of the organ. In these were detected no less than fourteen calculi, varying in size from a bean to a millet-seed, many of them facetted, of a dark mahogany colour. Over four ounces of offensive purulent urine escaped from the hilus.

On the third day the patient had symptoms of hypostatic congestion of the lungs, rapid breathing, lividity of the countenance, frequency of pulse, and elevation of temperature. These symptoms gradually subsided under the influence of carbonate of ammonia, and within ten days the patient was practically convalescent; pulse and temperature normal, tongue moist, and every indication of ultimate recovery.

The urine passed, after the first evacuation of the contents

of the bladder, was free from pus, gradually increased in quantity, averaging at the end of the week 32 ounces in the twenty-four hours. Morphia was administered hypodermically, in minute quantities, for the first thirty-six hours or so. The skin was encouraged to act freely, and no beef-tea was given, the patient being sustained by means of milk and soda-water, and subsequently small quantities of mutton broth.

Dr. BANTOCK remarked that, while it was very difficult to make a differential diagnosis in cases of disease of the uterine appendages, it was not so difficult to assure oneself of the existence of some form of disease. It must not be supposed that abdominal section was performed for the purpose of ascertaining whether there was any disease at all, but rather for the purpose of determining the exact nature of the disease. Abdominal section, as he understood and practised it, was not performed in cases in which the patients merely complained of pain in the pelvic region, and in which a physical examination furnished no evidence of local disease. On the contrary, he had in every instance satisfied himself previously as to the presence of some form of disease attended with enlargement of one or other of the generative organs within the pelvis.

With regard to nephrectomy, he thought an incision along the outer border of the rectus the most convenient when the tumour was over two pounds. About eighteen months ago a notice of a case of his appeared in the British Medical Journal, and Mr. Clement Lucas took upon himself to criticise adversely the primary removal of the tumour, contending that the proper course would have been to drain through the loin, and afterwards remove the kidney if necessary. It was scarcely necessary to point out that the draining of a kidney enlarged to about four pounds by tubercular pyelitis was not the simple thing which Mr. Lucas imagined it to be; that the patient would have had very little chance of recovery from such a procedure, and that the 'brilliant operation' had this to recommend it—that on the anniversary of the operation the patient was in excellent health. It is perfectly certain that that

could not have been said had Mr. Lucas's views been carried out; and he still believed that he had adopted the proper course, as he believed at the time.

Mr. LAWSON TAIT exhibited a large solid tumour of the breast, which had been growing for nearly twelve years. In appearance nothing that he had ever seen much resembled it, except the proliferating cyst described by Paget; certainly the resemblance to that was not very great, whilst the history was not consistent with it.

Mr. Tait also exhibited a large, soft, œdematous myoma of the uterus, which he had removed a few days before from another of the thirteen patients to whom he had alluded at a previous meeting of the Society as being in progress towards death, due to persistent hæmorrhage from uterine myoma. Of these thirteen, five have now been operated upon, all successfully, one by Dr. Keith and four by himself, and he was glad to be able to say that this, the sixth case, was also progressing favourably. Like the others, the patient had been under the care of a well-known surgeon for many years, and had been put off time after time, always hoping for something being done, but no active responsibility for an operation was really undertaken until she came under Mr. Tait's care. The tumour weighed 38 lbs.

On Exploration of the Uterine Cavity in cases of Metrorrhagia. By ARTHUR W. EDIS, M.D. Lond., F.R.C.P., &c., Obstetric Physician to the Middlesex Hospital, Physician to the Chelsea Hospital for Women, &c.

In bringing this subject before the attention of this Society, it is not with the object of enlightening my fellow gynæcologists, or criticising adversely the practice of my professional brethren, but rather of directing the notice of those who are not in the habit of resorting to this method of treatment to their responsibility—in some cases little less than criminal—and with the hope of encouraging them to a more frequent recourse to what is the only scientific and proper

mode of dealing with cases of severe, persistent, or recurrent uterine hæmorrhage.

I am induced to invite discussion in order that we may elicit the opinion of many present who are well competent to speak, and that the expression of opinion may prevent such irrational tampering with the lives of patients as I have unfortunately been called upon to witness.

The subject of persistent uterine hæmorrhage, usually described as metrorrhagia, is at all times one of much interest, and too frequently also one of much anxiety to the practitioner. The causes producing it are so numerous, the difficulties often of forming a correct diagnosis so great, and the consequences, not only to the patient, but also to the practitioner, so serious, that any attempt to classify the causes, simplify the diagnosis, or throw light upon the treatment cannot fail to prove of interest to all engaged in the practice of our profession.

There is unfortunately a tendency to treat metrorrhagia as if it were a special disease, in place of regarding it merely as a symptom of many and various different conditions. I propose discussing the subject from a practical rather than a theoretical point of view, treating it clinically, and making no attempt to give you a classical memoir.

A correct diagnosis is the first and most important element of successful treatment, for until we know the former the latter is mere guesswork, and we are as liable to do harm as good in attempting to repress the hæmorrhage. The principle of diagnosis by exclusion is one that approves itself to many—determining, in fact, to what cause the hæmorrhage is *not* due. This, of course, can only be done by knowing beforehand what are the most likely causes of severe hæmorrhage—the *possibilities*, so to speak—and then eliminating one after the other until we have left only two or more *probabilities*.

Speaking generally, there will be almost invariably some local cause detected if hæmorrhage be really severe, although complicating one or other of these conditions, or it may be

independently of any of them, the presence of cardiac, hepatic, or renal disorder should always be considered. These, again, may be aggravated by the injudicious employment of alcoholic stimulants, more especially about the time of the menopause.

The mere withdrawal of stimulants will often prove of much service in checking the flow, when pharmacopœial agents exert no beneficial influence whatever.

Numerous cases could be instanced exemplifying the truth of this statement. In fact, speaking generally, the less alcohol a patient takes who is suffering from metrorrhagia the better. I have repeatedly witnessed cases where the mere abstention from alcohol has been sufficient to arrest a profuse hæmorrhage which had been going on for many consecutive months, threatening even the patient's existence.

It is very important to bear this fact well in mind, for otherwise patients, by the advice of injudicious friends or at the promptings of their own suggestions, resort to such popular remedies as port wine and brandy with a view of keeping themselves up, when, in reality, they are doing themselves much harm by stimulating the circulation and interfering with the proper action of the liver.

In attempting to form a rational *diagnosis* as to the cause of profuse hæmorrhage in any individual case, it is of extreme importance to get a careful *history* of the case. How long has the hæmorrhage existed? did it come on gradually or suddenly? is it attended by pain? was there any intermission of the regular catamenial period? has the general health differed in any way? is there any mucous or offensive watery discharge between the occurrences of the hæmorrhage?

Before attempting to make any local investigation we should examine carefully the state of the heart, the lungs, the liver; examine the urine to see if there be any evidence of renal mischief; note the appearance of the tongue to see if there be any indication of the abuse of alcohol; enquire into the habits of the patient, whether sedentary or active;

and, in fact, ascertain all we can likely to throw light upon the individual case.

Before deciding to explore the cavity of the uterus, it is of course presumed that a most thorough and careful examination of the pelvic organs has been carried out.

Dilatation of the cervix uteri would clearly be contra-indicated if the history, symptoms, or signs pointed to the possibility or probability of hæmatocele, pyosalpinx, extra-uterine gestation, pregnancy with intense granular degeneration of the cervix, or other similar condition.

By a system of exclusion we must first narrow down the diagnosis to the probability of some intra-uterine complication. But if after a careful consideration of all the facts of the case the presumption is that we have this factor to deal with, then we are not justified in allowing our patient to go on bleeding indefinitely without giving her the benefit of further assistance.

A few words as to the method employed for dilating the cervix uteri. I have tried nearly all the various methods usually resorted to, such as gradual dilatation with laminaria, sponge, or tupelo tents; and more or less rapid distension with Hegar's, Lawson Tait's, or Aveling's dilators. Division of the cervix uteri with the metrotome or scissors, either alone or in conjunction with one or other of the foregoing methods, is that I more generally adopt when the existence of a fibroid is detected. I have never yet met with any ill results, and believe that if gradual dilatation be not unduly prolonged, in any case not beyond twenty-four hours, there is less bruising or injury to the cervix than if the more rapid mode of distension be had recourse to.

If then the cervix be not sufficiently dilated, after careful irrigation with iodised water, the metrotome may safely be employed, care being subsequently taken to render the cut edges callous, so that no absorption of septic matter takes place. It is always well in such cases to irrigate morning and evening with some appropriate antiseptic lotion for some few days following the operation. In cases of persistent hæmorrhage, due to the retention of the placenta following a mis-

carriage, the cervix generally remains sufficiently patulous, or is so readily dilatable by means of the finger or one or other of the methods of rapid dilatation, that no other means are required to admit of the requisite exploration and removal of the retained products. Where, however, only a small portion of the placenta has been retained, and the case allowed to go on indefinitely for several successive weeks, or even months, the cervix may be found so contracted as to necessitate the introduction of laminaria tents over night. In such cases incision should never be resorted to, this method being reserved exclusively for cases of small fibroids or fibroid polypi in the interior of the uterus.

The narration of a few typical cases will perhaps best serve to illustrate the importance of the subject.

Case I.

M. C., aged 38, single, a large, well-made woman of masculine type, consulted me in September 1882 for menorrhagia. She stated that she had been head-mistress of one of our Board schools, but had been compelled to relinquish her duties for the last three months in consequence of such profuse loss at her periods.

The catamenia commenced at the age of thirteen, were regular, lasting five or six days, unattended by pain or any marked discomfort. For the last few years the flow had been more profuse, lasting ten or eleven days and attended by pain. She suffered much from dragging pain in her back, bearing down, aching in the thighs, leucorrhœal discharge, palpitation, and other usual symptoms. She had consulted several medical men, but nothing beyond medicine had been suggested.

On examination, the uterus was found to be unusually bulky in size, mobile, somewhat irregular in outline; cervix, conical; os uteri, exceedingly small. The uterine sound passed nearly three inches and occasioned hæmorrhage. As she had taken large quantities of bromide, ergot, gallic acid,

sulphuric acid, and other similar remedies, any further temporising with the case was clearly contra-indicated. A laminaria tent was inserted over night, the cervix divided bilaterally, and the interior of the uterus explored. Projecting from the posterior wall was a small fibroid tumour, the size of a large walnut, sessile. The capsule was divided, and the tumour enucleated by combined traction and torsion with ovum forceps. Iodine was subsequently applied, ergot administered, and the uterus syringed out daily for the next few days.

She made a speedy recovery, and left for the seaside within three weeks of the operation.

When seen some few months later she stated that she now went one month between the periods, which only lasted four days. She had resumed her duties, and was to all intents and purposes perfectly well.

When first seen I was asked to certify as to her permanent disability to fulfil her school duties, in the hope of some small pension being obtained.

Comment is unnecessary.

Case II.

M. A., aged 50 years; married twenty-two years; three children, youngest nineteen years; one miscarriage. Catamenia appeared at eleven, and had been fairly regular, except when pregnant and suckling, until the last year and a half, since when they have recurred every fortnight, lasting a week, and accompanied by dragging, shooting pain, more especially in the right iliac region. Of late the pain had been more or less constant, preventing her walking, and interfering considerably with her sleeping at night. Her general health, consequent upon confinement to the house and her constant suffering, was much impaired, her digestion feeble, and her bowels very confined. She had been seen by several medical men, and was wearing a Hodge's pessary for supposed retroflexion of the uterus. She had been told that the case was an incurable one, and

doubts were entertained as to the malignant nature of the disease.

On examination, a hard, tender body was felt anterior to the uterus. The sound passed upwards and backwards, the mass anteriorly moving when the uterus was pressed forwards. The cervix uteri was granular, but did not bleed when touched, and presented no evidence of malignant disease. A sero-sanguineous offensive discharge was present.

The patient was advised to submit to exploration of the cavity of the uterus, in the hope that something might be done to relieve the profuse hæmorrhages and pain. This she did some two months subsequently. The cervix was dilated, the patient anæsthetised, and, after division of the cervix, the finger inserted into the uterus. A small sessile fibroid, the size of a bantam's egg, was discovered in the anterior uterine wall, pressing into the uterine cavity. The capsule was divided, and the fibroid enucleated by combined traction and torsion with the ovum forceps. The ordinary precautions were taken to prevent any septic absorption, and within six weeks the patient left for the seaside.

The pain and hæmorrhage ceased, and the patient began to regain health and strength. Two months later, on her return to town, she reported herself as considerably improved. The catamenia only lasted five days, and were unaccompanied by pain or other discomfort. The uterus had lessened materially in bulk, and, though still retroverted somewhat, was quite mobile, and caused little or no inconvenience in walking.

Case III.

M. H., aged 27; married five years; two children, youngest two and a half years; one miscarriage since last confinement Catamenia commenced at fourteen, and had been fairly regular, except when patient was pregnant. Eight months before being seen by me the catamenia ceased. Her husband then went abroad. She regarded herself as pregnant, but some three months after this she experienced rather profuse hæmor-

rhage consequent upon dancing. She rested up, and the hæmorrhage ceased, but recurred on the least exertion. This went on for the next few months. At the time of my seeing her she was much emaciated, had a foul tongue, little or no appetite, and was in a most unsatisfactory state. For three months past there had been more or less constant hæmorrhagic discharge from the vagina, at times very profuse. Ergotine, gallic and sulphuric acid had been prescribed, and the patient confined to bed. Applications had also been made from time to time to the cervix.

On examination, the uterus was found to be enlarged to the size of an ordinary two months' gestation ; the cervix was bulky, fissured, intensely granular.

Bearing in mind the fact that the catamenia had intermitted for three months before the hæmorrhage commenced, that her husband had been away for eight months, and that the size of the uterus was quite incompatible with such an advanced stage of utero-gestation, I had no hesitation in dilating the cervix uteri and exploring the cavity of the uterus. This was done, and a blighted ovum, so-called fleshy mole, extracted, after which the hæmorrhage ceased, and the patient in due course convalesced and regained flesh and strength. She was a somewhat delicate, fragile, fair-haired creature, and the strain upon her constitutional powers had been very great. The wonder was she had not succumbed. Grave doubts had been expressed as to the nature of her malady being malignant. The idea of exploring the cavity of the uterus never seemed to have occurred to those who had seen her professionally. Such cases as these are a reproach to us, and exemplify plainly the importance of a more systematic instruction in all that pertains to the diseases of women.

Case IV.

A. B., aged 38, single, a nervous patient, of spare habit of body, consulted me for severe dysmenorrhœa and profuse menstruation. The catamenia commenced at thirteen, were

always somewhat excessive, but, until the last two or three years, had not been accompanied by pain. She had consulted several physicians for nervousness, neuralgia, loss of strength, feeble digestion, constipation, and other symptoms due to the unusual drain upon her system from the profuse menstruation. Two of these had examined her and told her there was nothing wrong locally.

When first seen by me she stated that she was seldom free from sanguineous discharge for more than a week, the period often lasting ten to fourteen days, and was intensely painful. There was also a watery discharge when the sanguineous one ceased. On examination the uterus was found to be unusually bulky and mobile, the cervix very globular and soft, as if expanded over some growth within the uterus. The os uteri was very small, only admitting the uterine sound, which passed upwards and forwards three inches, causing bright hæmorrhage on withdrawal.

Considering that she had already taken ergot, ergotin, kino, hæmatoxylum, digitalis, iron, sulphuric acid, quinine, nux vomica, and other countless remedies, I placed before the patient the advisability of my exploring the cavity of the uterus. Although very averse to having any local treatment adopted, her condition was so critical her friends put pressure upon her, and she reluctantly consented.

For the past three months the hæmorrhage had been almost persistent, only a few days intervening between the cessation of one period and the commencement of another. She was so faint and her condition so exhausted as to necessitate constant lying up either in bed or on the sofa.

Watching my opportunity, the patient having rallied somewhat after a week's freedom from hæmorrhage, I dilated the cervix uteri, and was then enabled to discover a fibroid polypus, the size of a hen's egg, presenting at the os uteri. The patient being anæsthetised, I then divided the cervix uteri, and, seizing the polypus with my ovum forceps, succeeded in removing it by combined traction and torsion. It was well I adopted this method, for had I employed an

écraseur, there would in all probability have been severe hæmorrhage, the stump of the pedicle showing two vessels, each the size of a crow-quill, projecting at least one inch from the surface.

Liq. ferri perchl. was applied to the wound in the cervix, ergot administered, and other ordinary precautions adopted. The patient subsequently convalesced rapidly, and is now in the enjoyment of excellent health. When last seen, six months after the operation, the periods were normal in character, lasting only four days, not profuse nor painful, the interval being three weeks.

She had regained health and strength, was much less nervous, never suffered from neuralgia, and in every respect was better than she had been for some years past.

The polypus was evidently a fibroid tumour which had found its way to the internal surface of the uterus, and needed only a little artificial help to complete its removal.

Case V.[1]

G. S., aged 51 ; married twenty-five years ; mother of five children, youngest eight years old.

Patient had always enjoyed good health until her last confinement, eight years ago, since which time she had suffered from profuse and irregular discharges of blood, varying in duration from one to four weeks.

During the last four months the hæmorrhage had been almost continuous, attended by dragging pain in the left iliac region. On vaginal examination the uterus was found to be bulky, mobile, fairly normal in position, the sound passing four inches. The cervix, beyond a small induration in the anterior lip, was healthy and normal in consistence.

Dilatation was effected by means of laminaria tents, and the uterine cavity explored with the finger. A small nodular mass was detected, sessile on the fundus uteri ; this was seized with long ovum forceps and extracted by means of

[1] Published in *Brit. Med. Journal*, June 28, 1884.

torsion and traction. The interior of the uterus was then scraped carefully with a sharp curette, but no further nodules were detected.

Irrigation was resorted to, and the usual after-treatment adopted. Hæmorrhage ceased from this date, and the patient convalesced rapidly. The mass, not larger than the ungual phalanx of the forefinger, proved to be a placental polypus, evidently a relic of her last confinement, eight years before.

She had previously consulted several practitioners, but had only medicine prescribed.

It is needless to go on relating cases. Numbers of similar instances, which have occurred in my practice during the last few years, could be cited if that were necessary, but sufficient have been given to exemplify my meaning.

I am fully aware there are some who discountenance the enucleation of fibroids as being a hazardous method of treatment, and who also are opposed to division of the cervix ; but in cases such as I have narrated removal of the ovaries or appendages, or ablation of the uterus, would clearly have been uncalled for. In fact, until we have explored the cavity of the uterus, we are not in a position to form a correct opinion as to what method of treatment should be adopted. Without wishing to divert the discussion from the original purport of the paper, I would lay stress upon the importance of dilating the cervix and exploring the interior of the uterus in all cases where hæmorrhage from the organ persists unnaturally, and where the ordinary medicinal agents fail in affording relief, and there is no evidence of any condition external to the uterus sufficient to explain the persistence of hæmorrhage.

The treatment of persistent uterine hæmorrhage, depending upon the presence of fibroid tumours, would occupy too much time to discuss fully on this occasion.

The medical agents most likely to prove of service are ergot, nux vomica, gallic acid, cannabis indica, hamamelis, digitalis, vinca major, alum, iron in some cases, and other well-

known remedies. When these fail to control the hæmorrhage, local treatment should be resorted to. Dilatation or incision of the cervix, swabbing out the interior of the uterus with the liquor ferri perchlor., insufflation with iodoform, injection of carbolic acid, and various other means have been tried and proved successful in some cases.

Failing these, we are driven to the contemplation of more serious operations, such as enucleation, oöphorectomy, or hysterectomy. The choice of operation will depend mainly upon the size and position of the tumour and the age and condition of the patient.

Although instances of a fatal termination from severe hæmorrhage alone are far less common than might be anticipated, still, when we consider the amount of suffering involved by the constant drain upon the system, the deterioration of the general health, the impairment of the digestive functions, and the incapacity of the patient to fulfil her ordinary domestic duties, we are perfectly justified in resorting to operative measures, where other means have been fairly tried, and have failed to afford relief.

Professor Verneuil, in his recent address before the French Association for the Advancement of the Sciences, at Grenoble, threw out some excellent hints on the ethics of surgical practice. He affirmed that 'when the inefficacy of pharmaceutical and hygienic measures has been proved, and a necessity arises for operative procedures, choose always—and this is an inviolable rule—the least dangerous operation. This may in some instances be the boldest, the most radical, and apparently the most destructive.'

When a decision has to be made between two or more rival operations, a simple criterion is to put in the first place *efficacy*, in the second *harmlessness*, and in the third *facility*. There is also a second criterion still more valuable, and so simple that it can be applied in a few minutes, without any lengthened experience in practice or extensive learning, and without being acquainted with the procedures in favour at the moment in Vienna, London, or Berlin. I mean the Gospel

principle of doing to another what one would have done to one's self or one's own.

Dr. AVELING had observed that in cases requiring dilatation, where something existed in the uterus capable of being removed, the cervical canal was either dilated or dilatable; this peculiarity had been noticed by Harvey. In these cases he preferred to use his own dilator. Where the os was rigid and contracted, a more gradual method was better.

Dr. ROUTH believed the paper of Dr. Edis was eminently practical: he, however, thought it right to take exception to one or two points.

First, as to the rapid dilatation of the uterine cavity. It did not always succeed, as in cases of rigid uterus, and after all it was not a rapid but a long and tedious process, and complicated, as requiring chloroform; whereas dilatation by a sea-tangle, with proper precautions, was comparatively easy and safe. But then the tangles as sold in shops were not always safely usable, however smooth and pretty-looking on the surface. First, they were *straight*, and in a bent uterus their introduction was sometimes very difficult. Secondly, we never knew that they had been picked up *pure and fresh*, and, if not, the uterine moisture would set in action any septic matters contained. He therefore always collected his sea-tangles himself, and after having allowed them to soak in a solution of carbolic and iodine for two or three days, he thus purified them, and then let them dry in any shape. Thus he could always (having found the exact uterine shape by the sound) adapt a prepared tangle to the uterus, even if completely flexed, and so in no way force or injure the organ by the introduction of any tent. Nor did he care to give it a smooth exterior. It sufficed to cover it with cotton wool, and to moisten it with carbolic acid or iodine and glycerine, and no injury or poisoning could follow. The uterine cavity was thus ready for exploration, when some of those measures recommended by Dr. Edis could be adopted.

In regard to those cases of metrorrhagia in which nothing could be found after exploration (as well instanced by the

President's case just described), it should be remembered that ulceration or excoriation of the mucous membrane need not be restricted to the os and external portion of the cervix, but might extend high up the uterine cavity, even to the fundus, as often evidenced by the fundal pain and flow of blood on passage of the sound. Now it was quite in keeping with what occurred in piles; if the liver were very congested they would bleed and enlarge, and this was true for the mucous cavity of the uterus also. The late Dr. McKenzie had shown that in 75 per cent. of cases of menorrhagia there was *liver enlargement or congestion.* Mere ulceration of the lining membrane, if existing, could very often, like the President's case, be cured by the curette, which removed diseased surfaces, especially if iodine was applied afterwards, as it should always be.

The last objection he would take was the absolute necessity, if the os was cut by the knife or hysterotome, not to proceed to operate on the uterine contents till these cuts were healed, or *vice versâ*, if you were acting on the uterine contents, not to cut the cervix so long as a dubious discharge came *per* uterus; as assuredly, unless the most constant use of antiseptics to such wounds was insisted on, and the utmost antiseptic cleanliness enforced, you would poison a patient and have to lament an unfortunate death. Mr. Baker Brown had himself pointed out this risk, and Dr. Routh's experience was quite in accordance with it. There were few gynæcologists who could say they had not met such cases, and no precautions which could be taken could be too great to avert such a calamity.

Dr. BARNES desired to express his sense of the high practical value of Dr. Edis's paper. He himself thought that there was no law in therapeutics more clear than that which dictated direct examination of an organ at fault if we could effect it. We tried to do so in the case of the heart and lungs, and made the best approach possible by percussion and auscultation. The uterus offered the incontestable advantage of being directly accessible. He had accordingly many years

ago affirmed the proposition enforced in the paper—namely, to dilate the cervix uteri so as to get at the source of the hæmorrhage. He had stated the law in these terms: 'In all cases of hæmorrhage coming from the body of the uterus obtain and maintain free patency of the cervical canal.'

The indication, then, being clear to dilate the uterus, the question comes as to the best mode of doing this. In very many cases, perhaps in most, enlargement of the os externum is the most rational method. In many cases of metrorrhagia there is a narrow condition of the os externum, which is a factor in the causes of hæmorrhage, and which opposes local treatment. The enlargement is best effected by cutting either by scissors or a suitable knife. The incisions should be strictly limited. He very rarely saw occasion to divide the os internum. The immediate effect of incision was to relieve local engorgement. This was eminently beneficial in many cases. It was a benefit that no mechanical dilatation by bougies, tents, or expanding mechanism could accomplish. The next object attained was ready escape for imprisoned blood, clots, or mucus. Then there was free access for exploration and the application of topical remedies. The same practice was also especially useful in many cases of intra-uterine polypus, and fibromyoma of the body of the uterus. Here the incision of the vaginal-portion should be freer. Looking at the enormous tumour exhibited by Mr. Lawson Tait, of course nothing but extreme surgical treatment could be contemplated. But suppose we encounter these tumours in their early stage, then he was prepared to say, from the most positive clinical observation, that, in a fair number of cases, this incision of the cervix was followed by subsidence of metrorrhagia, and even shrinking of the tumours. And in a further proportion of cases the frequent injection of a solution of iodine promoted arrest of growth and diminution of the tumour. He had observed marked iodism produced by intra-uterine injections. What did this mean? It clearly showed that iodine was absorbed by a process of endosmosis or other mode, that it permeated all the tissues of the uterus, sound

and morbid; and the inference was justified that the iodine, thus coming into immediate contact with the myomatous growth, acted upon it, arresting its nutrition and promoting its atrophy. He had frequently observed that mere dilatation of the cervix was followed by arrest of hæmorrhage. He would not stop to discuss the merits of the various contrivances for effecting mechanical dilatation; some were certainly in many cases useful. The curette was useful in appropriate cases, but it must be used with discretion.

Dr. THOMAS SAVAGE said that all cases of uterine hæmorrhage requiring dilatation gave him a certain amount of anxiety. He had found Hegar's dilators to be very unsatisfactory, both for the patient and the medical man. Mr. Tait's dilators were not liable to give rise to septicæmia, but they had a great objection in that they required a considerable amount of skilled attention during the process of their operation; and they were apt sometimes to dilate the cervix only, considerably widening it in its wrong axis. Laminaria tents, as usually sold, were of little value; they required to be five inches long. In efficiency as dilators they were almost perfect; but they had the very serious objection of being sometimes followed by disastrous consequences.

Among his out-patients he frequently met with cases in which he suspected there was left behind some ovum remains, but which were not at all of an urgent nature. Here he, as a preliminary measure, thoroughly swabbed out the uterine cavity with a Playfair's probe dipped in pure carbolic acid; and he found that such a course would often prove sufficient for cure, and thereby save the patient from the troubles and risks of dilatation.

Dr. BANTOCK thought the best thanks of the Society were due to Dr. Edis for the admirable manner in which he had handled this important subject. While agreeing with him in the general principles of the treatment, he was compelled to dissent from him in one or two what might be called minor matters of detail.

It was well known that young girls under twenty were fre-

quently the subjects of menorrhagia, even of a severe form, which was quite amenable to constitutional treatment. He was not prepared to subject such a case to the whole gamut of the astringent remedies enumerated by Dr. Edis and usually recommended. After a fair trial—not too prolonged—of one or two approved remedies, he would not hesitate to have recourse to local treatment.

He did not approve of the practice of incising the internal os after partial dilatation for the purpose of removing a small fibroid tumour, because it would be impossible to control the subsequent extension of the laceration of the divided tissues, consequent on the forcible extraction of such a hard body as a fibroid tumour. In the discussion on Dr. More Madden's paper he objected to the method of enucleation and extraction by the vagina in the case of a tumour which could not be extracted through the artificially dilated cervical canal without incision. Nothing, however, could be more satisfactory than the results of this method in the case of small tumours.

It would be quite easy for him to support Dr. Edis's views by narrating cases exactly corresponding with those given by him. But this would be tedious, and he would content himself with a brief reference to a recent case resembling that mentioned by the President. A young married lady returned from India, about the beginning of the year, suffering from severe menorrhagia and metrorrhagia, which scarcely left her free from some hæmorrhagic discharge. The uterus was only slightly enlarged, and he had satisfied himself that there was no tumour. The patient had already had quite enough in the way of constitutional treatment, and he lost no time in resorting to local treatment. The cervical canal was accordingly dilated, and, as nothing could be detected by the finger, the cavity was freely curetted, with the result that several very small sago-like granulations were removed. After the curetting, the cavity was well swabbed with the strongest possible solution of iodine, applied through her uterine speculum. The result has been a complete success.

He thought it was a mistake to mix glycerine with iodine

or carbolic acid when the full effects of either remedy were desired, for in both instances the caustic effect was in this way reduced to a minimum, if not wholly removed. Especially was this the case with carbolic acid.

He had tried Hegar's dilators, only to be thoroughly disappointed with them, for dilatation could not be effected in a reasonable time without serious bruising of the tissues. He was, however, very much struck with the ingenuity displayed in the construction of Dr. Aveling's instrument, and he should take the earliest opportunity of trying it.

He did not entertain that dread of the tangle tent which seemed to exist in the minds of some men. There was something in the tangle tent which prevented it from becoming offensive. So marked was this peculiar property that he had frequently used the same tent two or three times, merely washing it thoroughly after use, and he had seen no ill effects. He therefore saw no necessity for the use of carbolic acid, as recommended by Dr. Routh.

There was another dilator which had served him well, and that was Molesworth's, the principle of which was elastic pressure. It would be impossible to exert any injurious pressure by means of this instrument.

He was not prepared to assent to the doctrine that a cervix which was the subject of even extensive disease of a non-malignant character, but the result of chronic catarrh, &c., should not be subjected to dilatation. These were just the cases in which he obtained the most satisfactory results from dilatation and the subsequent daily introduction of a strip of lint saturated with glycerine for ten to fourteen days.

Mr. LAWSON TAIT said that the paper they had just heard was an example of the kind of thing which would prove the Society to have a real use, for he believed that its highest function and its object was not so much to give an opportunity to specialists to discuss things from their own point of view, but rather to be the means of educating more completely in the ordinary lines of gynæcology those who had but few or no opportunities for special practice. There

could be no doubt that many good reputations had been marred by the presence of a small piece of retained ovum in the uterus being overlooked. When Harvey referred to the os being patent when there was something retained in the uterus, of course he referred only to such conditions as were associated with pregnancy, certainly not when the substance within the uterus was of the nature of a myoma.

Concerning the methods of exploration, he regarded sponge tents as the most deadly means. He had had the misfortune to have several fatal cases from their use, and had long since given them up. He had not had any disaster with the tangle tent in his own practice, but he had been called in to make an examination after death in a case in which the tangle tent had proved fatal by its being put through the fundus into the peritoneum in a case where there was a mass of myomata encircling the body of the uterus, the tent having been put in for the purpose of removing this growth, a proposition which could never have been carried out.

Hegar's dilators he regarded as most objectionable, because they were extremely risky and hazardous in their application; moreover, the employment of them was as exhausting for the operator as it was for the patient. His own method of dilatation had one objection, which had been pointed out by Dr. Savage. Like all other things of the kind, it required to be in the hands of competent persons, but otherwise it seemed to him free from any kind of objection. The dilatation could be carried on so slowly that not the slightest pain or inconvenience was experienced, while on the other hand, by the aid of a hypodermic injection of morphia, rapid dilatation could in a very few hours be accomplished. Whatever method was employed for dilating the cavity of the uterus, it was perfectly certain that a material like ebonite, which could absorb no fluid, was the only safe vehicle.

Dr. EDIS replied.

The Society then adjourned.

BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, DECEMBER 23, 1885.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 26 Fellows, 9 Visitors. The following gentlemen were elected Fellows of the Society:—Dr. C. J. Cullingworth, Dr. T. Harrison, Dr. W. Heiberg, Dr. W. Daniel, Dr. F. W. N. Haultain, Dr. J. A. Hopkins.

The following gentlemen were proposed for election:—Dr. James Jackson, London; Dr. H. P. C. Wilson, Baltimore, U.S.A.; Dr. Henry Ernest Watts, London.

Dr. BANTOCK exhibited the following specimens:—

I. A thick-walled suppurating cyst, removed from the left broad ligament of a married woman—Mrs. M.—aged 37, the mother of one child. The patient entered the Samaritan Free Hospital in the beginning of October. Three weeks after admission, while awaiting her turn for operation, the menses appeared. On the next day she complained of feeling unwell, and her temperature, which had hitherto been normal, was found to be 102·2. For three weeks efforts were made to reduce the temperature by antipyrin quinine, tincture of muriate of iron, but with little result. The patient was losing ground, and as it was most probable that the high temperature was dependent on some inflammatory change in the tumour, she was subjected to operation on November 14. The tumour was found situated in the left broad ligament; three pints of *very offensive* fluid were drawn off by the aspirator, the cyst not being quite emptied through blocking of the tube. While examining the relations of the cyst, an

opening was accidentally made through the envelope and cyst-wall at the bottom of Douglas' pouch, and the remaining contents escaped into the peritoneal cavity. As it was now impossible to think of draining the cavity, an incision was made in the envelope at the site of insertion of the aspirating needle, and it was found not difficult to remove the cyst-wall proper by enucleation. After this was effected, the envelope was divided as far as the hole in the bottom of Douglas' pouch, and the bleeding surface was thus thrown open and made part of the general peritoneal cavity. The loose flaps were secured by a chain of six ligatures, placed as low down and as close to the uterus on the one hand, and sigmoid flexure on the other, as possible, and a hand's breadth of broad ligament with the Fallopian tube attached was cut away. Then the pelvic cavity was twice filled up with plain warm water and well sponged out; a drainage tube was inserted, and the wound closed. The patient left the hospital within four weeks in very good health and rapidly regaining flesh and strength.

He was anxious to emphasise the fact that although at least half a pint of this most offensive fluid escaped into the pelvic cavity and amongst the intestines, the patient made an excellent recovery *without the use of any antiseptic whatever.* The cyst was evidently parovarian in its origin, arising in the long tube which, under the name of Gartner's duct, passes down by the side of the uterus, between the layers of the broad ligament.

II. A small but rapidly-growing fibroid tumour removed from a single woman, æt. 37, on November 24. The tumour took its origin in the left corner of the uterus, and in applying the serre nœud the corner was included along with the left ovary and its tube, but without opening the uterine cavity. The right ovary and tube had to be ligatured in the ordinary way. Patient quite convalescent; scarcely any rise of temperature.

III. Another fibroid tumour, removed, on December 9, from a single woman aged 34, who was suffering so much

from pain that she was unable to gain her living, and had been quite laid up for several weeks. The patient was a most unhealthy subject, presenting numerous scrofulous scars in the neck and other parts of the body, and with an open sore as large as a florin in the right popliteal space, resulting from the rupture of a vein. The tumour sprang from the fundus uteri by a very vascular pedicle, and was attached to the parietes on the right side, within half an inch of the abdominal (median) incision, by a thick band about one and a half inches broad. This was clamped with powerful forceps and afterwards ligatured. The pedicle was secured by the serre nœud, and both ovaries, with their tubes, were removed by ligature. Convalescence of the most favourable character; no rise of pulse, and scarcely any of temperature.

IV. (*a*) A multilocular tumour of the right ovary, from a woman aged 36, the mother of five children, removed on December 16. The interior of the largest cyst, at its base, presented a very characteristic patch of papilloma, about one inch long by half an inch broad, as well as small scattered centres of growth. The case illustrated the importance of not tapping even small ovarian cysts. The whole tumour only weighed three and a half pounds.

(*b*) The left ovary was a *multum in parvo* specimen, presenting early cystic disease of the ovary, early parovarian cyst, with one hydatid of Morgagni as large as a large hazelnut, and numerous smaller cysts around the tube.

V. The ovaries and tubes from a married woman, aged 46, the mother of several children. Menstruation ceased rather suddenly nine years ago, and ever since she had suffered from severe pain, which no treatment hitherto tried had in the slightest degree relieved. The diagnosis made was atrophy —probably cirrhosis—of the ovaries, with atrophy of the uterus, and was singularly confirmed by examination of the specimens. One ovary, *with its tube*, weighed sixty grains, and the other sixty-five grains. The operation appeared to have been remarkably justified, for in answer to the question, 'How are you?' the answer was (on the day of report), 'I

scarcely know myself; I am quite free from pain.' Operation on December 17, and, needless to say, convalescence perfectly satisfactory.

VI. The right ovary from a young lady, aged 20, from whom he removed at the same time a parovarian cyst of twenty-four pounds. In this ovary, which weighed in all twelve drachms, was a cyst containing six drachms of very dark fluid blood. On careful examination of the cyst wall, it was evident that fatty degeneration had already taken place, and had given rise to the hæmorrhage. The remainder of the ovary was in an early stage of multilocular disease. He had never observed hæmorrhage into the cyst at such an early period, and hence he thought the case worthy of public record. The case was, moreover, interesting as the first example of a B.A. of the London University undergoing the operation (December 23).

Dr. R. T. SMITH showed the specimens from a case of double hydro-salpinx.

The patient was 30 years old, married twelve years. She dated her illness from the birth of her only child, who was ten years of age. The symptom most complained of was a cutting pain in the left ovarian region, extending down the leg. The dysmenorrhœa was not severe, nor was there at any time any marked excess in the menstrual flow.

Having had the patient under observation for a year, and general treatment having failed to relieve the pain or to reduce the swellings felt in the pelvis behind the uterus, he determined to remove them by abdominal section.

The right tube was fairly free, and distended to the extent of holding two and a half ounces of fluid. The left was very difficult of removal in consequence of adhesions; it contained one and a half ounces of sero-sanguinolent fluid. The oozing of blood being considerable, a drainage tube was left in for three days. The patient recovered well, and with the exception of an elevation of temperature to 102°, and considerable pain following the removal of the tube, but subsiding the same day, no higher point than 99·4° was reached.

Dr. Smith remarked that the question raised by Dr. Routh as to the possibility of curing such cases by aspiration was worthy of careful observation.

He had opened the abdomen expecting to find two cystic ovaries, but these were to all appearance healthy, and were removed with the tubes. He would like to present the question to experienced observers: Would it be practicable to aspirate such tubes, and might not the possibility of child-bearing be left? It was a matter for careful clinical inquiry.

Dr. ROUTH said he thought the fact that a woman was completely unsexed by the extirpation of her tubes was scarcely enough considered. If an heir, or a child at any rate, were desired by the husband, he could no longer have one by his wife. Now, puncturing by an aspirator was perfectly free from danger, even if the contents of a salpingitis were offensive, because iodine could be injected, and thus the cavity cleansed, and in extreme cases a drainage tube kept in. It had been said that in these cases the Fallopian tube was hermetically closed already, and hence the woman was to all purposes incapable of conception.

One fact also served to confirm the view that a once-closed Fallopian tube could become pervious again: those cases where a tube was found so dilated as to admit the passage even of a large sound. Such cases had been incontrovertibly observed during life and found after death. Now this dilatation was clearly due in the first place to *retained* contents, which at last, and perhaps suddenly, were forced into the uterine cavity, but the tube remained unusually dilated. Such openings must, moreover, have been restored at *both* ends, for one could not otherwise have passed the sound through them into the abdominal cavity.

This could only be true when both tubes were affected. Still, as the diagnosis was not always certain, the use of the aspirator as a preliminary step commended itself as a common-sense measure. Suppose the obstruction was due to a twist in the tube, the puncture would then restore it, just as in cases of anasmia the penis might become twisted in itself, and if

punctured be restored to its normal position. But it was by no means sure that if inflammatory obstruction had occurred, that once the inflammation had been subdued the canal might not be restored. In cases of epididymitis, the canal was often for a time obstructed, so that the semen contained no spermatozoa, and yet later on they would appear—not invariably, it is true, but sometimes—when the inflammation had subsided. Then why should not a similar absorption take place in cases of salpingitis? So also in some cases of intense inflammation of the nasal cavities, one or both sides of the nose might be closed. Later on they would become even more patent when the inflammation had subsided. Then again, take a case of pus in the tympanic cavity, in which the Eustachian tube is closed; a puncture is made in the drum, and the pus liberated. After a time, when inflammation has been subdued, the patency of the Eustachian tube is restored. One or both ends of the Fallopian tube might be so restored. The very fact that after some of these punctures, or even after destruction of considerable portions of ovary, pregnancy recurred, as Dr. Smith had stated that night, encouraged this view. It left a hope behind it, which extirpation entirely destroyed.

Dr. BARNES did not wish on this occasion to enter upon a discussion of the best method of treating distended Fallopian tubes; he rose to recall attention to a point in the history of this subject which had been lost sight of. Tyler Smith, led by the analogy of obstruction of the Eustachian tube, which the late Mr. Yearsley treated by catheterisation, proposed and, he believed, practised catheterisation of the Fallopian tube. As he ingeniously put it, a dynasty might be barred by an atom of mucus in the tube. Of course this could only be practised at the uterine end. It was hardly likely that occlusion of the fimbriated end could be successfully dealt with by catheterisation. And looking to the necessarily changed condition of the lining membrane of the tube when it has been the seat of distensions from inflammatory and other effusions, the hope of so far restoring the integrity of the tube as to fit

it for the function of transmitting an ovum, impregnated or fit for impregnation, into the uterus must be slender indeed. He entertained no doubt as to the feasibility of catheterising the uterine end of the tube. He had seen Tyler Smith demonstrate it on the dead body; and the shape of the fundus uteri with the infundibuliform disposition easily conducted the point of the sound to the orifice of the tube. Smith used a fine flexible whalebone sound. This could not perforate the uterine wall as the ordinary uterine sound had probably often done. If tapping was indicated, it might be possible to tap through this route. But the diagnosis once fairly made out, he was of opinion that Tait's plan of removing the tubes by laparotomy was the most rational.

Dr. GRIGG stated that he thought Dr. Routh's suggestion a possibility, and believed he had seen a case in the post-mortem theatre where such had happened. It was in a case of a woman who died shortly after delivery at Queen Charlotte's Hospital. She had miscarried about five years previously, and had had, as she stated, puerperal fever afterwards. The right broad ligament was full of various-sized encysted abscesses, one of which completely blocked up the Fallopian tube at its uterine extremity. On the left side the Fallopian tube was found hypertrophied and with a distended cavity, but was pervious throughout. It conveyed an impression as if it had at some time or other been distended with fluid, and the plugged orifices had become reabsorbed, admitting of the passage of the ovum.

DISCUSSION ON LACERATION OF THE CERVIX.

Dr. BANTOCK, in resuming the discussion on Dr. R. T. Smith's paper, thought he would be expressing the sentiments of those who had listened to it in acknowledging the very able and temperate manner in which the subject was presented, free as it was from prejudice, without over-laudation on the one hand, or undue depreciation on the other.

He would prefer to see the word tracheloraphy, or trach-

elorrhaphy (as it was variously spelt), abandoned, and the name 'Emmet's operation' substituted, as being not only much more simple and euphonious but as indicating both the exact nature and site of the operation and as conveying a well-merited compliment to its originator.

Although he was unable to boast of a large experience of this operation, yet he might say he was well acquainted with the literature of the subject, and the conclusion he had come to was that while there was undoubtedly a wide field for the operation, he was equally convinced that it was performed much too frequently. This was admitted by no less an authority than Dr. Goodell regarding his own practice; for he says: 'Of the beneficial results of trachelorrhaphy I must candidly admit that I am not now so sanguine as at first. Cases have disappointed me; but then, on the other hand, I have undoubtedly operated on some cases unnecessarily.' Even Emmet himself tells us that he now operates on a much smaller number than formerly. It is inevitable in the case of a new operation that it is sometimes performed unnecessarily and in unsuitable cases; but that is not an argument of any weight against the operation *per se*, and we need not be surprised when we find several of our American brethren enumerating their cases not by modest tens and scores but by hundreds. It is very possible, and not at all improbable, that the necessity for this operation exists to a greater extent in America than in this country; for I think it is admitted that midwifery *in the mass* is much more skilfully practised in this country than in America. Still it is not unnecessary to curb the fiery zeal of young operators who are anxious to emulate the deeds of their seniors, and I believe no one is more alive than Emmet himself to the danger his operation runs of being brought into discredit by his over-zealous disciples.

As might naturally be expected, Dr. Emmet holds very strong and pronounced views as to the results to be obtained from this operation, and, no doubt, rightly so in a large majority of cases. One of these views is that the repair of ulcerated cervix will suffice for the restoration of a retroverted

uterus when the two are combined. He could well understand that a large, top-heavy, sub-involuted, partially retroverted uterus might be benefited by this operation, and involution so hastened that, in a shorter space of time than otherwise would have been the case, the uterus might right itself on attaining to its normal size. But his experience was opposed to this contention in the case of a well-marked retroversion. In illustration of this he briefly related the case of a lady, aged twenty-nine, who came from one of the midland counties to consult him on July 4 last. She was the mother of four children, and had never been well since the birth of her youngest, five years ago. On that occasion the labour lasted three days. On examination the uterus was found very much retroverted, and the cervix very badly torn bilaterally—to the reflexion of the vagina. She had worn several different kinds of pessary, adapted by as many practitioners, and another had even recommended her to have the ovaries removed. As the patient had made her arrangements to return the same day, all he could do was to try the effect of another pessary. For the time she was relieved, and as long as the uterus remained in its place; but as the organ sank down into the pelvis and fell backwards, the posterior transverse bar of the instrument, drawing the posterior lip backwards instead of the cervix as a whole, again separated the lips, even aggravated the condition of ectropion, and caused her so much pain that in two or three days she was compelled to remove it. He performed 'Emmet's operation' on August 12, and on August 21 (or tenth day) removed the sutures (silkworm gut)—with one exception—the wound being then perfectly healed by first intention. On October 12 she returned with the uterus still as much retroverted as ever, and he then introduced the same pessary (Hodge's) as formerly proved inefficient. The result appears to be quite satisfactory. The suture that had been missed on August 21 was at the same time removed. There was not the slightest irritation around it.

Dr. Emmet is very careful to cut away the cicatricial

tissue from the angles of the fissure, believing that this is the cause of the patient's acutest sufferings. This view is not confirmed by Goodell, who says, 'When, however, I have operated on a tear without ectropion, or merely on account of cicatricial tissue in the angle of the fissure, I have been grievously disappointed.'

On the other hand, while Goodell advises the performance of the operation in cases where hereditary tendency to malignant disease exists, Emmet tells us that he has never been able to trace an hereditary tendency to any form of malignant disease in connection with a lacerated cervix, an opinion which is confirmed by his (Dr. B.'s) own experience.

In this country the operation has not yet gained that recognition which it deserves. He would illustrate this by another case, viz. that of a lady aged thirty-eight, who was sent to him by a medical friend in the neighbourhood of London, on June 18 last. She had had six children in five pregnancies; the youngest child was one year and nine months old. Amongst other symptoms she complained of more or less constant aching in the pelvic region. She had consulted an eminent obstetrician and gynæcologist, who pronounced the case one of lupoid ulceration of the os and cervix and recommended the hot douche and constitutional treatment. As she had not at all improved after several months' perseverance in this treatment she was sent to him. Examination revealed a large, sub-involuted uterus, with a two-lipped, widely gaping os, the result of a bilateral, but unequal, laceration; there was no trace of ulceration or even of excoriation, and certainly not of lupoid ulceration—whatever that might be—but there was some glairy discharge from the cervical canal. After the application of a strong solution to the latter, the patient was recommended to continue the hot douche, and was advised to have 'Emmet's operation' performed. To this she at once consented, and it was accordingly done a month afterwards, viz. on July 20. Perfect union by first intention resulted, the sutures being of silkworm gut. Two months after this the patient's general

health had very much improved, and her old symptoms had disappeared, though the uterus was still a little too large. He had no doubt as to the ultimate result.

He was, then, of opinion that deep laceration of the cervix should be treated by this operation, but that the cases of fissure, especially those of radiating or stellate fissure, usually of no great depth, might be let alone, and that when the state of congestion and hyperplasia, so often present in these cases, and which exaggerated appearances, was appropriately treated, the necessity for the operation would disappear with congestion and hyperplasia. Emmet admits that his views were materially modified by the case of a young unmarried virgin, whose cervix presented the appearances of ectropion from laceration, but which he found was due to congestion. The cervix resumed its normal appearance under suitable treatment. The result of that experience is that he now operates on a much smaller number than formerly, and he holds that the preparatory treatment in many cases is necessary before the necessity for an operation can be determined upon. We could not do better than follow such a safe guide as Dr. Emmet.

Dr. AVELING said he was glad of the opportunity of bringing before the Fellows a method of treating ectropic erosion of the mucous membrane of the cervix uteri, which he had employed for some years with uniform and permanent success. Ectropic erosion might be caused by laceration during labour, by undue division of the cervix, and by eversion of the cervix in complete prolapse. He treated all cases of ectropic erosion by adustion, a term used by Harvey, which included searing and igni-puncture. Searing cures the erosion: igni-puncture the hypertrophy arising from the erosion. A large wooden speculum should be used, and the introduction of this is the most painful part of the operation, sometimes necessitating the use of ether. Paquelin's cautery is employed. The operation is quite safe, the only after-inconvenience noticed being an occasional disturbance of the bladder, but this lasts a very short time. The operation is also short and easily performed.

Dr. Aveling stated that he had been performing this operation for many years and in a very large number of cases. Many of his patients had been confined afterwards, and no return of the erosion had taken place. He had performed Emmet's operation a few times, but thought in the majority of these cases adustion was the best mode of treatment.

Dr. FANCOURT BARNES said that lacerations of the cervix frequently occurred spontaneously during the passage of the child through the os uteri. They often completely healed spontaneously, and could not be attributed in any way to the manner in which the labour was managed. He thought that the greater frequency of lacerations of the cervix in America than in England was due to climatic influence. He could not agree that the actual cautery was sufficient to restore the cervix to a natural condition after deep laceration; nothing but Emmet's operation could do this.

Dr. MANSELL-MOULLIN had had the opportunity of seeing many of the operations upon which Dr. R. T. Smith based his interesting paper, and had performed the operation many times himself with very good results. He considered the operation was a great advance in gynæcological surgery, and afforded a rapid and effectual means of bringing about a cure in a large class of cases which hitherto had been a standing opprobrium. He had only himself operated in cases in which the laceration was deep and well marked, presenting a large, raw, and granular surface, but he was so satisfied with the result that he felt inclined to extend the operation to those in which the laceration was lesser in extent, but where there existed a certain amount of ectropion and erosion. These were the cases which went the rounds of the profession, being cauterised for months together first with one caustic and then with another, always, however, with the same negative result. He thought Dr. R. Smith had well defined the case in which operation was likely to be beneficial, viz. whenever the gaping labia could be approximated and rolled inwards. Dr. Mansell-Moullin had remarked a decided

tendency to abort in cases in which the cervix was deeply lacerated. It seemed only natural that after the cavity of the uterus was distended by a four or five months' ovum, its retaining power should be diminished by the injury to the lower portion. He felt certain, although pregnancy often did go to full time, yet nevertheless the tendency to miscarry was very great in such cases.

Dr. ROUTH said: Admitting to the full the philosophical character of the paper read, and the great credit due to its author, he thought that this operation had been too especially urged—at least for English practice. It might be different in America—not because the obstetricians and even midwives were in any way inferior in their knowledge, but because in the wilds of America there were often not only no doctors near, but not even midwives: women being delivered without proper aid by other ignorant matrons, it might be by their husbands, or the veterinary practitioner in the neighbourhood. Hence laceration of the os uteri, like vesico-vaginal fistula, was more common. The question would naturally suggest itself at the outset here, When such cases occurred in this country before the American pracice was recommended, how did the women get well? Now, in the course of a very large experience, he (Dr. Routh) had only seen one case which he could not cure by the actual cautery. Not only did he use Paquelin's but an ordinary iron which could be heated at an ordinary fire—sometimes quite rounded, sometimes sharp. He had seen the practice years ago at the Hôpital St. Louis carried out by Jobert de Lamballe. He used it commonly for nearly every kind of ulcer. He had his little stove by his side with his irons heated, and as each woman passed in review she was seared more or less on the os, through a bone or wood speculum, and sent on. He did not believe this plan, however, any more than trachelorrhaphy, would cure retroversion, but it would cure an uninvoluted, inflamed, ragged state of that organ. The very sloughing-off of the eschar produced a drain upon the uterus, and thus reduced it in size. The woman needed not to be detained in bed.

The operation might be repeated, and even assisted by a preliminary depletion by leeches, but the cure was generally complete in a month or six weeks. Cleanliness and avoidance of fatigue were all the after-treatment needed—nor was it necessary for the woman to keep away from her house duties, if carried on with discretion and moderation. He was at a loss, therefore, to see the use of this new operation for these cases, being amply satisfied with that of the actual cautery, and herein he could confirm fully all that had emanated from Drs. Robert Barnes, Aveling, and the other speakers.

Dr. BEDFORD FENWICK thought that these cases could be successfully dealt with by Emmet's operation or by the cautery, but the operative treatment was more speedy.

Dr. FENTON-JONES thought that in certain conditions and degrees of laceration of the cervix uteri, both Emmet's operation and the plan of treatment suggested by Dr. Aveling gave very excellent results. The truth was that cases of lacerated cervix varied much both in degree and as to the symptoms to which they gave rise. There were, roughly speaking, three classes of this injury, one which, probably because the lips were not everted, gave no trouble whatever, the torn surface healed over, the process of involution was not interfered with, and there was no leucorrhœa, no pain in the back, and no other symptom which only would be discovered as existing on account of an examination being made for some other purpose.

Then came a large class in which the symptoms were well marked with regard to the pain, to the imperfect involution, the discharge, dysparæmia, &c., all of which would be due not so much to the laceration itself as to ectropion. Get rid of the highly vascular and highly secretive surface, get contraction of the turgid lips of the uterus and promote involution, and your case was cured. All this could be done, as Dr. Aveling suggested, by searing and by igni-puncture with Paquelin's cautery. Dr. Fenton-Jones strongly advocated its use in such cases, because it not only did all that was wanted, but could be used by almost any medical man; was a simple

and a safe method; and the patient was up and about in a week or ten days after operation.

Then there was a far less numerous class of case in which the laceration was deep, there might or might not be ectropion with its attendant troubles, but the containing power of the uterus was lessened as evidenced by abortions: such cases he thought should be reserved for Emmet's operation. The diversity of opinion as to treatment which had apparently arisen that night amongst the Fellows was probably more apparent than real. When speaking of these two lines of treatment they probably had in their minds two distinct classes of cases.

Dr. R. T. SMITH stated in reply that he was quite aware that Dr. Barnes had given in his second edition of the 'Diseases of Women' a careful and appreciative account of the value of Emmet's teaching and method of treatment, and he was glad to have his authoritative approval. In Dr. Bantock's condemnation of the word trachelorraphy he himself shared; he had never used the word. Laceration of the cervix was a clear, expressive title of the diseased condition, and 'Emmet's operation' was very definite, and was also a well-deserved eulogium of the chief exponent of the doctrine. With Dr. Bantock he also agreed in the statement that retroflexion was not always cured by the operation, but the uterus was so diminished in size, and its resilience was so increased, that the ordinary means of treating retroflexion were now successful.

In answer to Drs. Aveling and Routh, while admitting that the cautery and caustics would lessen indurations and cause diminution of size, he could only maintain that the healing of a neglected wound by vivifying the surfaces and their healing by first intention was preferable to that of applying any form of caustic with the subsequent sloughing and healing by granulation. Of the great saving of time, and of the less amount of painful treatment, there could be no doubt whatever.

The Society then adjourned.

THE ANNUAL MEETING OF THE BRITISH GYNÆCOLOGICAL SOCIETY.

WEDNESDAY, JANUARY 13, 1886.

DR. MEADOWS, PRESIDENT, IN THE CHAIR.

PRESENT: 43 Fellows; 2 visitors. The following gentlemen were elected Fellows of the Society:—Dr. J. Jackson; Dr. H. P. C. Wilson; Dr. H. E. Watts. The following gentlemen were proposed for election:—Dr. J. Henry Carstens (Detroit, U.S.A.); Dr. Arthur B. Carpenter (Cleveland, Ohio, U.S.A.); Dr. Christian Fenger (Chicago, U.S.A.); Dr. de Laskie Miller (Chicago, U.S.A.); Dr. John Inglis Parsons (London); Dr. John Johnston (Maidstone); Dr. Edward George Whittle (Brighton).

Dr. THOMAS SAVAGE showed a solitary galls-tone, about the size of an ordinary marble, successfully removed by cholecystotomy. Before operation, a distinct tumour was felt, although urgent symptoms had existed only eight days. The gall-bladder was very much thickened, and contained about six ounces of viscid transparent mucus. The stone was impacted in the cystic duct, and required a scoop for its removal. Six interrupted silk sutures were used for stitching the bladder and closing the wound.

Mr. REEVES inquired if Dr. Savage's case of gall-stone had any connection with pregnancy, as there was no doubt of the frequency of that condition as a cause, either predisposing or exciting, of gall-stones. He related two cases to the point from his own practice, and further stated that the malady was not so very uncommon in infants and young children as

supposed, and quoted the baby of one of his cases of gall-stones as an instance, and said that others were recorded.

Dr. AVELING exhibited a modification of Dr. Meadows' compound Hodge-and-stem pessary, to be used in cases of extreme retroflexion. It obviated the difficulty met with in Dr. Meadows' instrument, viz. the loosening and breaking of the india-rubber bands.

Dr. BANTOCK, while admiring the ingenuity displayed by Dr. Aveling in devising his instrument, was not prepared to admit that it was superior to the President's form. Dr. Aveling's instrument admitted of forward as well as backward movement, but the former was alone necessary. He thought the stem was too rigidly fixed, and if it yielded to the only displacing force to which it was exposed—i.e. backward—there was nothing to restore it. This was provided for in the President's instrument, and since he had altered the mode of fastening the india-rubber band he had not been annoyed by its giving way. While his objections might be regarded as theoretical, he would still feel it his duty to give the instrument a fair trial.

Dr. ROUTH, while fully admitting the advantages of both Dr. Meadows' and Dr. Aveling's modification of it, yet thought that they had some inconveniences. The uterus completed in health a curve with the vagina. Both these instruments had the tendency to bring the uterus at right angles with the vagina. In his (Dr. Routh's) buckle pessary, the position was kept to as near the normal angle as possible. However, like Sir James Simpson's instrument, though to a less degree by Dr. Meadows' and Dr. Aveling's instruments, the uterus was fixed, having only an anterior and posterior movement provided for it, whereas in the normal condition the uterus moved in every direction. This Dr. Routh's buckle pessary permitted, the stem playing in a diaphragm in a ball-and-socket joint; in fact, it was an ordinary Hodge with a cross bar in its upper third, in the centre of which was affixed the stem playing in the ball-and-socket joint. As the first *cul de sac*, however, was sometimes longer

than at other times, means were provided to allow the cross bar to be moved backwards or forwards. He would take the earliest opportunity of showing the instrument to the Society in its various forms, although already shown to the British Medical Association.

Dr. HEYWOOD SMITH said the multiplicity of pessaries arose in consequence of extraordinary and difficult cases of malposition of the uterus. For ordinary cases the Hodge's pessary and its modifications usually sufficed, but it was when we came across specially obstinate cases that special appliances were necessary, and it was in these difficult cases that so many pessaries failed. Even in that one which Dr. Routh had described failure was often due to the india-rubber band being inadequate to resist the forcible pressure of a stiff and chronic retroflexion, for the uterus bent the stem over and remained in its abnormal condition. He did not understand in what way Dr. Aveling's modification of the President's pessary was an improvement, as in very obstinate cases he had found that pessary a very useful one.

Dr. FANCOURT BARNES showed the ovaries he had removed from a patient aged 31, married nine years, I.-para. She had been suffering from metrorrhagia for one year. During the last six months she had been getting worse, in spite of general and local treatment. There was a myoma of the uterus which had been increasing in size. Since the operation of oöphorectomy the hæmorrhage had ceased, and the tumour had decreased considerably in size. In other respects marked improvement had occurred, and the patient was much relieved. Since the operation she had menstruated with only a slight loss and no pain.

Mr. LAWSON TAIT exhibited a drawing which had a certain amount of historical interest. It was an example of either hydro- or pyo- salpinx, most admirably depicted in water colours, and had been given him a few days before by his old master, Dr. Keiller of Edinburgh. Dr. Keiller had used it in his lectures from 1850 to 1879, and the drawing itself was done, probably, about 1845. The drawing showed

two distinct cases: the first of which was of the acute or early part of the disease, whilst the second drawing exhibited the contracted tubes with adhesions, such as are found in cases of very long standing, now so frequently relieved and cured by operation.

Mr. Tait also showed a specimen from the University Museum at Edinburgh, which he was enabled to submit to the Society by the kindness of his friend Professor Simpson. It formed the subject of a lecture which Mr. Tait was privileged to deliver in the University to Professor Simpson's class, and was a post-mortem specimen removed from the body of a young prostitute, in whom there had evidently been very serious perimetritis, with double pyosalpinx. The ovaries and tubes were adherent in a very characteristic fashion, representing from their position all the difficulties which are so frequently found in the operations for dealing with this disease. The specimen was peculiarly valuable because it was the first example Mr. Tait had ever seen of these conditions displayed so that they could be actually inspected. It was just in such a case where, when the tubes and ovaries were removed by the operator, very little indeed could be seen the matter with them. Yet the operations in such cases were certainly amongst the most difficult feats in surgery, the hæmorrhage alone being enough to stop the inexperienced operator in the middle of the proceeding. In spite of all these difficulties, spectators of the operation could see nothing beyond the operator's two fingers digging away in the cavity of the pelvis, and what difficulties he encountered they had to take entirely on trust. In very many such cases, in his own practice, where Mr. Tait had experienced the gravest difficulties in removing the appendages, when they were removed they had hardly any appearance of being other than normal. This was fully displayed by the specimen, because if the appendages in this case were taken out from their surroundings, as is the case in the operations spoken of, they would be regarded, after a few hours' soaking in spirits, as perfectly unchanged by disease.

Dr. THOMAS SAVAGE quite confirmed what Mr. Tait had said about the difficulties experienced in picking out adherent appendages. They were often so buried and covered by bands of adhesion that on first entering the pelvis one was inclined to think that there were no ovaries or tubes present.

Dr. ROUTH thought that as Mr. Lawson Tait and Dr. Bantock had shown so much skill in completely extirpating adherent ovaries and tubes, he would be very glad to find that they had, by practice, attained to the greater skill of disentangling these adhesions in practicable cases, and not extirpating, and so allowing women to keep their sex a little longer, and give them the chance of some future baby.

Dr. BANTOCK was able to illustrate and confirm some of Mr. Lawson Tait's observations by one of the most recent cases of ovariotomy he had done, about a fortnight previously. After removing a large ovarian tumour from the left side, he examined the right side according to his invariable custom. The ovary, which was apparently not diseased, was completely shut in by adhesions of the tube around it. Dr. Routh, who was interested in the case, was present, and the question arose as to the propriety of removing the parts. Dr. Routh was against it, but thought it best to remove them, and it was fortunate he did so, for on examination a small collection of grumous matter was found in a small sac, formed by adhesion of the fimbriated extremity of the tube to the ovary. Moreover, the tube was bent into the form of the letter U, with the tops of the limbs approximated, and there fixed by adhesions. This condition of things explained the pain from which the patient had suffered for many months. He thought the material results that would be obtained would far outweigh any moral considerations, on which Dr. Routh appeared to lay so much stress.

The TREASURER (Dr. Edis) then read the following report:—

RECEIPTS AND EXPENDITURE FOR THE YEAR ENDING DECEMBER 31, 1885.

Dr.

	£	s.	d.
To Annual Subscriptions	290	17	0
„ Life „	115	10	0
„ Foreign „	52	5	0
	458	12	0
„ Preliminary Expense Fund	37	16	0
	496	8	0

Cr.

	£	s.	d.	£	s.	d.
By Messrs. Smith, Elder, & Co., for publication of Nos. 1 and 2 of 'British Gynæcological Journal'				127	2	0
„ Messrs. Slaughter & Colegrave, law charges for establishment				47	7	0
„ Rent of Medical Society's Rooms				47	0	6
„ Postages, preliminary and Editor's expenses				25	0	0
„ Printing, stationery, &c.				21	18	4
„ Advertising				0	17	0
„ Petty cash				3	0	0
„ Shorthand writer				2	2	0
„ Bank charges				0	7	4
				274	14	2
	£	s.	d.			
„ Balance, Bank	194	3	9			
„ „ Cash	27	10	1			
				221	13	10
				496	8	0

Examined and found correct.

Signed by { JOHN CHALMERS, M.D.,
J. S. WOOD.

January 26, 1886.

LAWSON TAIT, F.R.C.S.,
President.

Dr. SAVAGE proposed and Dr. R. T. SMITH seconded 'That the Treasurer's report be received.' This was carried.

The PRESIDENT then announced the new list of officers and council for 1886. (See page 505.)

Dr. AVELING proposed and Dr. CULVER JAMES seconded the adoption of the list as nominated by the council. This was carried.

The PRESIDENT (Dr. Meadows) then delivered the following address:—

An Address on the work and progress of the British Gynæcological Society. *By* ALFRED MEADOWS, M.D., F.R.C.P., President.

ONLY ten short months have elapsed since I delivered from this place the Inaugural Address at the first meeting of this Society. My first words on that occasion were those of grateful acknowledgment to you, gentlemen, for the high honour you had conferred upon me in electing me as the first President of a Society which I felt confident would ere long be able to boast of a success second to none in the history of medical societies in this country. To-day, ere I vacate this chair, I desire to express my heartfelt thanks for the unvarying courtesy, kindness, and consideration which has been shown to me by my colleagues in the council chamber, and by the Fellows of the Society at the meetings over which I have had the honour to preside. The confident expectation which I expressed as to the success of this Society has, I am pleased and proud to say, been more than verified; and I believe I am fairly entitled to say that as a society we occupy a position to-day which, whether it be regarded from the standpoint of our numerical strength, or from the character and quality of the work which we have done, as recorded in the Journal of our Transactions, is one that we may all be justly proud of. If there were sceptics who doubted the wisdom or questioned the propriety of founding a new society with the objects we had in view, their criticism, I venture to

say, will hardly do credit to their foresight when confronted with the historical facts which form the record of our first year's existence. As a matter of fact, I believe that the objections which were taken and the opposition that was raised to the formation of this Society were not of a high scientific order, or the result of any conscientious desire to advance or encourage the study of gynæcology in this country; but these objects were certainly uppermost in the minds of those who originated this Society; and we may well feel, as we look back upon the record of our first year's history, that we have wrought a good work, and that we have not only added to our stock of knowledge by mutual intercourse with each other, but that we have left our mark upon the scientific record of the year, and have added to the total sum of human knowledge for the benefit of mankind.

If this be so—and I challenge any one competent to express an opinion on the subject to deny it—then I say that we have not only established our claim to existence, but we have made that existence an absolute necessity for the work which we are called upon to do—work, too, which would certainly not be done except by such a society as this. Measured merely by the numerical standard, I believe that no other medical society can show such a marvellous record of success, nor do I know of any other test by which to gauge the popularity of a movement such as that which led to the foundation of this Society. The fact that 260 Fellows had joined our ranks when I delivered the Inaugural Address at our first meeting is sufficient evidence, I think, of the appreciation in which it was held, and is conclusive testimony that it supplied a want which was very generally felt; while the fact that over 120 Fellows have subsequently been elected is conclusive proof of the continued interest which is felt in the prosperity of the Society, and the strongest testimony to its utility and attractiveness. Moreover, the attendance at our meetings, which has been in point of numbers fully equal to that of any other medical society, notwithstanding that we meet fortnightly instead of monthly as is the rule with most other societies, is

additional proof of our success, and evidence of the interest taken in our proceedings. Nor is it merely or chiefly from London that our Fellows are derived, nor even from the British Isles alone, but we have on our muster-roll as ordinary Fellows of the Society the names of gentlemen from all parts of the world, more especially from America and France. Among our Vice-Presidents, and therefore as ordinary Fellows of the Society, we have the names of Pinard of Paris and Mundé of New York—men whose names are familiar as household words wherever the science of gynæcology is recognised; so that not only is this Society rightly designated British, but it might also be called universal.

Speaking from a pretty large experience of other medical societies in this metropolis, I can truly say that I know of no other society the ordinary meetings of which attract Fellows from such distances as does this. I believe we have never held a meeting at which there were not present representatives from some of the largest provincial towns, as well as from the capitals of Ireland and Scotland. Birmingham, Manchester, Liverpool, Wolverhampton, Dublin, and Edinburgh have all furnished materials and men to illustrate our work and enhance the interest and attractiveness of our meetings, by bringing together into one focus, as it were, a mass of experience of the most varied order and scientific attainments of the highest mark. Hence, the discussions which have taken place here have possessed, as I ventured to hope and to predict they would, an educational value which cannot be overestimated. In my Inaugural Address I made the remark that 'if this Society fulfilled its proper mission, it may, and in my opinion it ought to, become a great educational institution,' and I have always regarded this as one of its most valuable features. Even we so-called specialists have I venture to say, learnt much during this our first session, and the large number of our brethren in general practice who have attended our meetings must, I think, have thereby gained much valuable information which cannot but be useful to them in their daily work.

And, gentlemen, this fact leads me to make a suggestion, or at least to throw out a hint for your consideration. I have long felt that this great city, the largest, the wealthiest, and the most intelligent in the world, with its boundless medical resources, and its vast field of gynæcological experience, ought to possess an hospital for the study and practice of gynæcology far superior to anything that exists at present, either here or abroad. Moreover, when we consider the position, character, and wide experience of those who practise gynæcology, the undoubted popularity of special hospitals (more particularly, I would say, those for the treatment of the diseases peculiar to women)—a popularity which, I am convinced by the experience of more than a quarter of a century of special and general hospital work is greatly in excess of the popularity of the special departments of our general hospitals; when we remember, too, that there is no really great school of gynæcology in this metropolis, no educational facilities worthy of the name or equal to the importance of the subject—we must, I think, admit that there is a great want to be supplied; and I know of no body of men so capable of supplying that want as the Fellows of this Society. It would, indeed, be a grand scheme in connection with a British Gynæcological Society—one which would perfect and complete our work, and be unique, I believe, in the history of a scientific society—if we could start and maintain—not of course by ourselves, but by public assistance, and as it were in affiliation with this Society—a *School of Gynæcology* which should be at once worthy of this great metropolis, capable of doing a vast charitable work, and above all devoted to the education of senior students and medical practitioners in the daily growing importance of the study of the diseases peculiar to women. If the collective influence of the Fellows of this Society were directed to the establishing of an institution of this kind; enlisting as it would do the sympathy of thousands who can appreciate the value and usefulness which such a work would possess, I do not see why there might not be reared up in this city an Institution

which would surpass anything of its kind that has hitherto been in existence, a something that would form a centre of attraction to gynæcologists in all parts of the world, and something, too, that would assuredly make for this Society a position absolutely unique among the medical and scientific societies of the world.

Referring to the numerical strength of the Society, I may say that, including the names of those nominated to-night, our muster-roll has now run up to 400!—a number which, I believe, is wholly without parallel in the history of any similar society, seeing that it is only ten months since we started on our career, of which two months were vacation time, so that we have only had one short session of eight months! Up to the end of 1885 we have held sixteen meetings, with an average attendance of 40 Fellows and visitors present at each meeting. We have had a vast array of specimens exhibited, and these in themselves have afforded evidence of an amount of work done which, for its quality, is, I believe, unique. One cannot help regretting that such a collection of valuable specimens is not preserved in a museum as the property of the Society. Their educational value would thus be perpetuated, and they would form an interesting monument of the Society's work. I venture to hope that some day this want may be supplied in connection with the institution to which I have referred; and where also I would hope to see established a library of still greater value and utility, in which possibly our meetings might also be held, thereby effecting an important saving in the working expenses of the Society. Should such a library ever be established, I will undertake to bequeath to it the medical and scientific works which I have collected.

And here I would make one remark in reference to the Journal of the Society, which is at present our only literary property. No one, I think, who has seen that journal will contradict me when I say that for artistic effect, for typographical excellence, and for general external appearance, it reflects the greatest credit upon the editor, Dr. Fancourt Barnes, who is alone responsible for these qualities, and

deserves the thanks of the Fellows; while as to its scientific contents, I think, as representing the first year of our work, it is a journal and a record of which we may feel honestly proud. That it is appreciated, too, by the profession is evidenced by the fact that one of our numbers had to be reprinted as a 2nd Edition. I think, it is a very great advantage that our transactions are thus published quarterly, instead of waiting till the end of the year, especially as the Journal contains not only particulars of our own work, but is also a record of the whole subject of gynæcology at home and abroad, and, as such, possesses a very special value. Only those who are acquainted with journalistic work can appreciate the labour which such a journal entails; but the Society is to be congratulated on having secured the ready, willing, able, and most valuable services of Dr. Fancourt Barnes, whose experience as the former sub-editor of the 'British Medical Journal,' under the able guidance of Mr. Ernest Hart, is the best guarantee that this work will be carried to a successful issue, and that our Journal will not only be a credit to our Society, but a valuable addition to the gynæcological literature of our time.

Another matter which the Council has taken in hand during the past year, and upon which a committee is now actively engaged, is the subject of 'The Relation of Menstruation to Ovulation.' I ventured in my Inaugural Address to suggest that a small working committee should be formed to collect and sift the mass of evidence which exists on this subject, and to give us a report which might be discussed and criticised with great advantage. I cannot imagine a more useful work for such a society as this than the collective investigation of evidence on doubtful scientific questions connected with our special department of practice. All such work may go on simultaneously with the clinical and practical work of our lives; and thus much of abstract scientific knowledge as well as of practical therapeutics may be the outcome of such a society as this, and the best possible evidence of its utility and value.

I may here call attention to the fact that already, and quite incidentally, in the course of one of our meetings, a brief discussion arose on this much-disputed point of the ovular theory of menstruation, which only seemed, as it were, to whet one's appetite for a full and thorough investigation and discussion of the subject. For myself, I must confess that my belief in this theory has been very rudely shaken of late. I have met with cases where pregnancy has occurred without menstruation; where, therefore, ovulation occurred without menstruation; and I have also seen the converse of this, where menstruation has gone on without ovulation, for the simple reason that there were no ovaries to ovulate, they having been removed for the anticipated arrest of the growth of a large uterine fibroma. At the present moment I have one such case under observation—the patient menstruates regularly and profusely though I removed her ovaries more than twelve months ago. We know, too, it is not uncommon to find women menstruating during pregnancy when ovulation is generally supposed to be in abeyance; and again, pregnancy will often occur without previous menstruation, as, for instance, during lactation. Here it is obvious that ovulation occurred, but there was no resulting menstruation. All this shows how extremely unsettled and unsatisfactory is the present condition of this most important question; and I earnestly hope that the Committee now at work on the subject will be able at all events to throw much light upon it, even though it may not finally settle it. There ought to be a good deal of material in the possession of the Fellows of this Society; and I hope those who hear me, and those, if any, who may read this Address, will favour the Committee with any information they may possess.

It is not my intention—and I hope that in this respect at least the example I am setting will be followed by my successors in this chair—to occupy the time of the Annual Meeting with any obituary notices of Fellows who may have been taken from us during the past year. Such a record finds, I think, its appropriate time and place in the current numbers

of our Journal; and certainly it does not, in my opinion, add either to the interest or to the enjoyment of our Annual Meeting. Happily, in the past year we have had but one death among our Fellows, and in the second number of our Journal will be found a very interesting account of his life and work. I refer to the late Dr. William Johnson Smith of Weymouth. May it be years before our Journal records another!

Turning now to a brief mention of some of the subjects which have been discussed during the past year, I would put in the forefront, as being the most interesting and the most important, the discussion on uterine fibromas, which extended over three nights, and was originated by an admirable paper; though I dissent from many of the opinions advocated by the author, Dr. More Madden. It is not too much to say that that discussion, and the specimens of this disease which have been exhibited here by Dr. Bantock, Mr. Lawson Tait, and others, have advanced considerably our views of the proper treatment to be adopted in these cases; and as I took no part in that discussion, I may perhaps be allowed now to make one or two observations on the subject. It will be recollected that the author objected rather strongly to the practice of treating these cases by hysterectomy, or indeed by any surgical proceeding, on the ground that the disease very seldom ends fatally, and that therefore a formidable operation is not called for, and can only be regarded as justifiable in very exceptional circumstances. Wide differences of opinion were proved to exist among the Fellows of the Society as to the danger of leaving these cases alone; some, though a very small minority, regarding them as comparatively harmless cases; while the experience of others, and that a large majority, showed that fatal results are by no means infrequent. It is obvious that the question of the propriety of resorting to surgical interference depends in great measure upon whether the disease is or is not to be regarded as one involving any danger to life if left alone. Speaking from my own experience, I have no hesitation in saying that a fatal issue in the ordinary

history of these cases is by no means so rare as is sometimes asserted. Nor is it merely by gradual exhaustion and continued loss of blood that death not infrequently occurs; for there are other more sudden and more certain causes of death which were not mentioned during the discussion. I have seen again and again inflammatory attacks occurring in the tumours themselves, and leading in some cases to suppuration within the substance of the tumours, and to subsequent death by pyæmia; while in other cases phlebitis has occurred and death has resulted from pulmonary embolism. Two such cases occurred in my practice within the last two years. Sir Wm. Jenner saw one of them with me. Both of these might, I believe, have been saved had the patients consented to surgical interference; but they had been told that the disease was perfectly harmless, and therefore refused to have anything done to rid them of it. I have seen many cases of inflammation of uterine fibroids, and I always regard the condition as one of extreme gravity, for the course of the inflammation is very uncertain and erratic, and liable to accidents, so called, of the kind above mentioned. I have also seen several cases end fatally by gradually exhausting discharges, while others have terminated more suddenly by violent losses of blood. I well remember, years ago, being called suddenly to a case of violent flooding which had come on while the patient was walking in the street. She was carried home, and died in a few hours; but before she died I found that she was the subject of an intra-uterine fibroma, for which she had long been under medical treatment, which I do not hesitate to say was worse than useless; but she was told that the disease was perfectly harmless, and that at the change of life it would disappear! She, however, died before that happy change occurred. My experience therefore is dead against the opinion as to the harmlessness of these growths, and I entirely dissent from the statement of Dr. More Madden that 'the mortality of an ordinary uterine fibroid, if left alone, is nothing approaching a death-rate of 8 per cent.' Hence, I am an advocate for more frequent resort to surgical interference,

and I should regard a death occurring in the history of a uterine fibroid as casting a great slur upon the professional reputation of the attending practitioner.

On the question of enucleation *versus* hysterectomy, I also entertain a very decided opinion adverse to the former, except in certain clearly defined cases; and I would lay down this rule with regard to the question of enucleation, viz. that in all cases where the entire cervix is perfectly healthy and altogether free from the disease, which is, therefore, limited absolutely to the fundus and body of the uterus—that in all such cases enucleation is wholly inadmissible, and hysterectomy ought to be performed. The cervix in such cases forms an admirable pedicle or stump, and the whole disease, being above the cervix, is well within the compass of removal by abdominal section. Where, on the other hand, the disease is in one or other uterine wall, and invades the whole cervix, so that the anterior or posterior lip is occupied by the growth which thus projects into the vagina, *there* the disease can and ought to be attacked, for it is easily accessible per vaginam, and can, as a rule, be easily shelled out from the loose cellular bed in which it is developed.

As to the medicinal treatment of all these growths, I expressed a very decided opinion years ago, which subsequent experience has amply confirmed—that it is worse than useless, and I would say scarcely honest, to attempt any such with a view to cure; it is mere waste of valuable time, and, so far as the patient is concerned, an equal waste of valuable money.

Upon the question of the removal of the ovaries in these cases for the arrest of menstruation, and consequent arrest or the cure of the disease, my experience has thus far been decidedly favourable; though, as I have already mentioned, I have one case now under observation where the removal of the ovaries twelve months ago has not been followed by the cessation of menstruation, and the growth is still increasing in size. Nor do I think that this proceeding can have more than a limited application, viz. to those cases in which the growth is certainly not larger than a fœtal head at term, where the tumour is

also interstitial, and therefore liable to flooding, and where the patient is under forty years of age. It should be remembered too, as in favour of this operation, that while it is not one which is attended with much risk, its failure for the purpose in question does not preclude us from subsequently resorting to the more radical method of complete extirpation of the disease by hysterectomy.

I think the Society may certainly be congratulated on the advance it has made during the first year of its existence on this one topic, not only in the discussions which it inaugurated, and the record of which in our Journal marks an epoch in the history of the subject, but also in the amount of work done, as shown in the truly remarkable series of cases brought forward and specimens exhibited—probably no such specimens were ever exhibited in the same time in any society before.

Another very interesting and suggestive paper was that of Dr. Bell on dysmenorrhœa. The condition of which it treated is so common, and the veiws entertained by gynæcologists regarding its pathology and treatment are so diverse, that much good must follow the publication of a paper so thoughtful and philosophical. Moreover, as a protest against what the author regarded as a too mechanical tendency in the treatment of this affection, it would undoubtedly exercise a thoughtful influence over the minds of gynæcologists. At the same time I feel bound to say that my own experience accords very closely with that of most of the speakers in the belief that in a very large proportion of the cases of dysmenorrhœa, the pain is entirely due to mechanical defects of a more or less obstructive character, and is only to be successfully combated by mechanical interference. It is well, however, that we should now and then have our attention called to the work which others are doing in what I may term the anti-mechanical field of uterine therapeutics. There is no doubt, I think, that the natural tendency of the busy life we lead is rather towards a narrowing of the field of our mental vision in proportion to the activity of our occupation. We seem,

sometimes, to live almost too fast even to think, and such a habit of over-activity and preoccupation tends rather to limit and contract our mental vision, and thus to cause us, as it were, to run too much in a groove, and to be satisfied with insufficient inquiry. Hence, a paper like that of Dr. Bell calls upon us to halt and reflect; and though we may go on again, working on the same lines as before, yet the halt will have done good even if it only confirms us, after mature reflection, in the opinion we previously held.

A brief but very interesting discussion arose upon a specimen, brought forward by Dr. Fancourt Barnes, of the kidneys of a woman who had died of albuminuria in pregnancy. The opinion seemed to be very general, but certainly not universal, that in all cases of albuminuria in pregnancy abortion ought always to be induced. I cannot altogether accept this doctrine, and the rule which I would recommend is this: that we should first of all differentiate cases of albuminuria in pregnancy into two classes—1st, those in which the disease is recent and acute; and 2nd, those in which it is of long standing and chronic. The symptoms in these two cases are generally very plainly marked, and the microscope will usually distinguish between the two with unerring precision; for while casts will be found in both cases, they differ materially in their character and significance. In the chronic variety they are of large size, granular, and sometimes contain secreting epithelium upon their surface; while in the more recent and acute form, the casts are small, waxy, transparent, hyaline, and not at all granular. Hence the distinction is very marked, and so are the symptoms; and the treatment in the two cases ought, I think, to be widely different, and to be based upon these facts; for as the chronic variety is not likely to be made much worse by the pregnancy, the acute form is pretty sure to become chronic if the pregnancy is allowed to go on. Moreover, interference of a surgical kind is far more likely to be attended with mischievous results in the former case than in the latter; for we have abundant evidence to prove that surgical operations cannot be performed with impunity in

persons who are the subject of chronic renal disease. This was indeed illustrated painfully in the case brought forward by Dr. Fancourt Barnes. But this fatality is by no means the rule in cases where the albuminuria is recent and acute; operative interference is here tolerated not only with impunity but with manifest relief to that condition which calls for the operation. Again, in the case of the chronic variety, the life of the mother is, if I may say so, to some extent relatively of less value than in the other class of case, because she already has a mortal disease, and therefore the life of the child has a stronger claim upon us, and we should do what is best for it by allowing the pregnancy to go on. For all these reasons, then, I would lay down this rule: That in chronic cases, such as that brought forward by Dr. Fancourt Barnes, no interference with the course of pregnancy should be attempted—it is dangerous to do so, fatal to the child, and we cannot thereby prevent the development of the disease which has already become permanently established. In recent and acute cases, on the other hand, operative interference is well tolerated, to the evident relief of the symptoms—the disease is thereby prevented from becoming chronic and so ultimately endangering the mother's life; and lastly, the child's life is of less value when put in comparison with that of the mother, which is certainly threatened if the pregnancy goes on. Such is the rule which I would venture to lay down for future guidance in these cases.

Time does not permit of my referring to other papers, which I might well do, for we have had abundant material for comment, for criticism, for eulogy, and for congratulation as to the work which this Society has done—work eminently practical, thoroughly scientific, and certain to live for all time.

May I be pardoned now if I venture to make one or two observations which have about them a tinge of adverse criticism on the work which we have done. Where all has been so good it may perhaps not be very gracious to find fault, nor do I wish to do so, but only to point out other fields of labour in which I think abundant harvests may be

reaped. It is, I confess, with a slight feeling of disappointment that I survey the work of the past year in order to find what has been done in regard to uterine therapeutics. There has been a singular absence of any well-recorded observations of the value of drugs in the treatment of uterine diseases. I am myself a firm believer in the use of drugs. To me practice would be shorn of its greatest attraction if I did not feel confidence in the things I prescribe: and what we sorely need here is a number of accurately recorded observations of medicinal treatment, that we may know what is useful and what not, and, if possible, the reasons why. We shall look in vain in the past numbers of our Journal for much information, much evidence of work done, in this department. With the single exception of the medicated *tampons* exhibited by Dr. Fancourt Barnes as illustrating a new mode of applying remedies, we have had no novelty in medicinal practice brought forward. Dr. Chalmers, in his well-recorded case of sloughing of the vagina, certainly detailed some very careful observations in practical therapeutics. We want many more such, and I think we must probably look for them rather from the less operative Fellows of the Society. True, there was, one night, brief reference made to the value of iodine in the treatment of certain uterine diseases, but this reference served rather to illustrate the proverbial saying that doctors differ; because while one eminent authority declared that iodine is most valuable when used in conjunction with glycerine, another no less emphatically stated an exactly opposite opinion. It is obvious that there must be some mistake here, and what we want is such accuracy of observation that errors of this sort are impossible. In my Inaugural Address I gave special expression to the hope that during our first year of work we would record many accurate histories of exact therapeutical observations which would add to our treasury of useful knowledge, from which our professional brethren, and especially those engaged in general practice, might largely draw for the benefit of those whom they might be called upon to treat. At present my hope in this respect

has not been realised; and ere I vacate this chair I would again earnestly invite those Fellows of the Society who have special opportunities for observing the effect of drugs in gynæcological work to give us the benefit of their experience, in order that the teaching value of this Society may receive its fullest and most useful development.

There is another little criticism which I would venture to make in the form of a mild protest against what I fear may become the too surgical tendency of this Society. We must remember that it is not given to all of us to perform the splendid operations which we have had detailed to us over and over again during the past year by those whom we may well regard as the leaders in gynæcological surgery. Moreover, the mind is apt to become satiated with these sensational novelties, and to be unfitted thereby for the more quiet but none the less useful routine of daily practice; and I venture to think that he who will perfect our daily work, by adding to our therapeutical store knowledge of an *exact* kind, will do quite as much, though in a more quiet and unostentatious way, to earn the gratitude of suffering women, as he who performs the most brilliant operation before a wondering and admiring audience. Pray do not let it be supposed that I undervalue the splendid surgical achievements of Lawson Tait, of Bantock, and others; or the less showy but useful work described by Dr. R. T. Smith in his highly suggestive and philosophical paper on the operation for the cure of lacerated cervix uteri; or, again, the operation, originated by Dr. Alexander, of shortening the round ligament for obstinate and severe cases of retroflexion. I admire these achievements as much as any one, and I think they do infinite credit to the skill, the ingenuity, the courage, and the patience of their performers; and the record of their work must ever be honourable to this Society. But for all that, we must take care not to be too one-sided, and especially we should be careful not to be too surgically minded in our practice, or to think that the record of surgical work only is the one thing needful in such a society as this; for in proportion as we

do so we limit the sphere of usefulness of this Society, and to that extent we sow the seeds of ultimate decay and dissolution.

There is yet one other criticism in regard to the past work of this Society which I am anxious to mention, viz. the conspicuous absence of all reference to what I may call the diagnostic faculty in most of the papers and discussions which have been brought under our notice. I cannot help regarding this as a question of serious moment—one which certainly requires consideration, and which I shall hope to see more frequently referred to in the future work of the Society. There are many cases of gynæcological disease the symptoms of which are sufficiently obscure to need the closest scrutiny and minute observation; and those of us who have such special opportunities for observing them should record their experience, especially with regard to differential diagnosis, for the benefit of the less experienced Fellows. I have on several occasions endeavoured by questioning to elucidate doubtful points of diagnosis in regard to cases which have been brought forward as examples of surgical work. We should be careful not to make the Society too much of a display of operative triumphs. Rather we should aim at perfecting in ourselves and others the faculty of accurate diagnosis and minutely careful clinical observation; for it will, I think, in the majority of cases be found that accuracy of diagnosis will generally lead to successful treatment. Where mistakes in treatment are made, it will be due, I believe, more often than not to errors in diagnosis. Take as an illustration of these remarks the subject of diseases of the Fallopian tubes, pyo-salpinx, hydro-salpinx, hemato-salpinx: can it be said that these conditions are yet perfectly easy of diagnosis? We have had many specimens of diseased tubes brought before us in the past session, sometimes half a dozen or more in one evening! but I am not sure that their diagnosis before operation was in all cases clearly made out. If it was, I do not think the Society, at all events, got the benefit of the author's experience in such a way as to make the diagnosis of these

cases at all certain in the practice of others. I would like to see all such doubtful and difficult observations made clear in the future to any Fellow of the Society, so that they too might be able to diagnose with the same apparent facility. If this were done, not in these cases only, but in other diseases which are brought before us, then I think one of the chief functions, and certainly one of the great uses, of this Society would be amply demonstrated.

Lastly, there is one other topic I would like to touch upon in furtherance of a wish I expressed in my Inaugural Address, viz. that those of our Fellows who are engaged in general practice would now and then favour us with some of their experiences, and would tell us of their doubts and difficulties in gynæcological work. It would, I am sure, greatly enhance the value of this Society, and add largely to the interest of our meetings, if such of our Fellows would more frequently engage in the discussions, even if it were only to ask questions; and I trust that during the current year we may be favoured by some papers or the details of some cases, with or without the exhibition of specimens, from some of the general practitioners who honour us with their presence. I am quite sure of this, that their remarks will at all times, whether in the form of papers or in our discussions, be received with great pleasure, and add considerably to the interest and enjoyment of our meetings. We have already had two such papers, and occasional remarks have been made; and I venture to say that there have been no better reported cases, and no more valuable remarks made, during the past session than in the papers by Dr. Chalmers and Dr. Bennington. I sincerely hope their example will be followed by many others during the present session, to the great advantage, as I am confident it will be, of the Fellows of this Society. Moreover, such work as this will, I am sure, prove very attractive to those who have not yet joined our ranks, and thus our Society will be enlarged and our sphere of usefulness extended.

And now, gentlemen, I have finished. I fear I have

wearied you with these tedious and rather commonplace observations, for which I ask your indulgence. The time has arrived when I must vacate this chair, which by your kindness I have occupied during the past year. No one knows better than I do my many shortcomings during my year of office, and no one can have felt more keenly than I the responsibility which rested upon me as your first President. It is no light matter in these days of marvellous scientific development to undertake to found a new scientific society; and certainly those who do so should understand what they are about, and give proof of the reality and seriousness of their work. I do not think we shall have much to fear on this account when the day of reckoning comes. I rejoice to know that the wonderful success which this Society has achieved up to the present time—a success which I believe is without a parallel in the history of medical societies—has been due far more to its own inherent vitality than to the character and work of its first President. Certainly, I have taken, and shall continue to take as long as I live, the deepest interest in its welfare and success, and, to the utmost of my power and ability, it will be a genuine pleasure to me to promote its prosperity and extend its usefulness. Nor can I doubt that what you have done to-night, in the choice of my successor, has been done wisely and well in the best interests of the association. Considering the title and composition of the Society, I think it was both a graceful and a right thing to do to choose a President from among the provincial Fellows. Mr. Lawson Tait has by his work demonstrated that he is a consummate master of his art, and he is known to be a man of the true scientific type. Moreover, he is a man of great force of character—fearless, honest, thorough, and straightforward; in fact, just the sort of man that I would wish to see ever at the head of affairs of the British Gynæcological Society. I congratulate you on the choice which you have made, and him on the honour he has received.

Once more, gentlemen, I thank you most heartily and

sincerely for your kindness, your consideration, and the compliment you paid me when you placed me in this chair. Believe me, I am not likely ever to forget it; and in taking leave of you as your President, I can express my gratitude in no better terms than in wishing you God-speed in this and all your undertakings.

Dr. BARNES rose with unqualified satisfaction to propose a vote which he was sure would be received with unanimous applause. The vote was designed to convey the thanks of the Fellows to their accomplished President for the singularly able and masterly address they had just heard. It was difficult to give adequate acknowledgment of the services which their retiring President had rendered in the difficult task of starting a new society. He had displayed in an eminent degree the qualities of a successful founder. The faculty of initiation, one of the highest, was his. Capacity to command the business of the society, urbanity and scientific grasp to conduct pleasantly and profitably the proceedings at their meetings, were happily combined. He would not intrude on the meeting any comments on the President's summary of the leading scientific questions which had occupied their attention during the session. That summary exhibited at once his grasp over the subjects discussed and his judgment in deducing his opinions. Dr. Barnes thought that Dr. Meadows' suggestion that one of the functions of the society should be to work as a school for instruction in gynæcology was a most excellent one; and with his assistance it would surely be carried out successfully. Dr. Barnes concluded by congratulating the society upon the brilliant success it had attained, and the services it had already rendered to gynæcology under a free and liberal organisation.

Mr. LAWSON TAIT said he rose to second the vote of thanks to the President for his address, but he felt that, owing to the kind allusions to himself in the concluding sentences, this duty had better have been performed by some one else. With the tenor of the address Mr. Tait entirely agreed,

and more particularly would he like to emphasise his agreement on two points. The first was that considerable preponderance of the surgical aspect of gynæcology had been evident in the work of the past session ; but he was of opinion that this was inevitable, for two reasons. In the first place, the conditions of the science which marked the time of the foundation of the Gynæcological Society had led to a great upheaval of the surgical side of the art. Indeed the rapid advance of surgical gynæcology had led to the formation of the Society as a protest against the discouragement which had been received elsewhere. Mr. Tait was, however, by no means inclined to minimise or to subvert the aspect of gynæcology as seen from the altitude of the physicians. Dr. Meadows was a Fellow of the College of Physicians, and therefore would be inclined to give way to his surgical *confrères*. He (Mr. Tait), on the contrary, was a Fellow of the College of Surgeons, and during his year of office he would see that as little surgery as possible was talked.

The second point on which Mr. Tait desired to emphasise the utterances of their retiring President was the allusion he made to the desirability of hearing more from the mouths of general practitioners. This was most essentially important in the present aspect of affairs, because he could only say that that part of the story which was yet unwritten in gynæcology chiefly was that part of the history which could only be given by the family medical attendants, the early stage of the diseases which special surgeons and physicians were called upon to treat. Until such as himself were taught by the family medical attendant the accurate course and exact history of the early stage of these diseases, they would remain to a very large extent untaught. He sincerely trusted, therefore, that during his year of office his friends who were engaged in the closer habitual attendance of families as their trusted advisers would largely contribute to the discussions of the session.

The PRESIDENT returned thanks.

The Society then adjourned.

REVIEW.

The Science and Art of Midwifery. By WILLIAM THOMPSON LUSK, A.M., M.D. Third Edition, pp. 763, with numerous illustrations. (London: H. K. Lewis, 136 Gower Street. 1885.)

IT is with much pleasure we welcome the third edition of this most excellent work. The immense progress which has taken place in obstetric practice since the first edition was published, some three or four years ago, has necessitated many changes in the text, and has led to the nearly complete rewriting of entire subjects. Statements which, three years ago, were advanced with diffidence as theoretically probable have in many cases been shown to be capable of scientific demonstration; others with more modern light have been omitted in the process of revision.

The present edition displays throughout an immense amount of labour and careful discrimination, and amply fulfils the author's modest expectation that it may prove a safe guide to the practice of midwifery and a useful book of reference. It is in every respect a most valuable addition to the literature of obstetrics.

J. MANSELL-MOULLIN, M.D.

SUMMARY OF GYNÆCOLOGY, INCLUDING OBSTETRICS.

Modified Operation for Cystocele.—Reamy (A. T.), the 'Medical News,' August 8, 1885. The author first gives a short summary of the operation practised by Dieffenbach, Sims, and Emmet. The condition which it is sought to remedy is one of more or less prolapse of the anterior wall of the vagina, accompanied by a dragging down of the posterior wall of the bladder.

Dieffenbach's method, which consists in an elliptical denudation of the mucous membrane of the anterior vaginal wall and closing the edges by suture, is suitable in slight cases. It is, however, open to the objection that in severe cases it causes a deformity of the vagina, on account of the extent of mucous membrane which has to be removed.

Sims employed a similar method, but did not remove the mucous membranes from the centre of the ellipse, thus leaving an elliptical rim of freshened surface, which was brought into apposition by means of sutures. In this case the tension in the centre is so great that the sutures often cut their way out, and, even when success seems to have been obtained, the line of union is so narrow that stretching of the parts is liable to occur, and so render the operation useless.

In Emmet's operation the two-thirds of the freshened surface nearest to the cervix resembles the elliptical form of Sims, but the posterior portion is crescent-shaped, having its concavity towards the urethra. But here, again, the central portion of the mucous membrane is retained, so that the line

of union is narrow, and the parts are liable to give way. There is also some difficulty in securing union at the lower angles, which has led Emmet to modify his operation, but the number of his more recent cases is not sufficient to allow us to form an opinion as to its value.

The author has performed his own operation fifty times during the last eight years. The patient being placed in the lithotomy position, Sims' speculum is introduced, and a constant stream of water at 100° F. is allowed to play on the part to be denuded during the operation. This has the effect of controlling hæmorrhage and allowing the parts to be well seen. A sharp-pointed, curved pair of scissors is used in the vivifying. The portion of vivified surface nearest to the urethra is triangular in shape, the apex of the triangle pointing towards the urethra. From its base spring two lateral branches, spreading along on each side of the cervix. These are also somewhat triangular-shaped, the apex being outwards. When the surfaces are brought together, the line of union resembles the letter Y. The author relies greatly for the success of his operation in cutting deeply near the bifurcation of the denudation. At this point he recommends that the cellular tissue between the vagina and the bladder should be reached, failing which the operation will not succeed.

In two cases he has wounded the bladder, causing a vesico-vaginal fistula, which healed readily, being closed by the same sutures that were used for the cystocele. Care must be taken in denuding the lateral branches that too great a depth is not attained, on account of the risk of wounding the ureters. Closely placed sutures of carbolised silkworm gut are used in bringing the surfaces together. After the operation the patient is placed in bed, and a self-retaining catheter kept in the bladder for eight or ten days.

The advantages over other methods claimed by the author for this operation are: (1) simplicity and ease of execution; (2) less width of denuded surface is required; (3) the deep dissection necessary to secure success is safer; (4) the results are more permanent, on account of the tension being less at

any one point; and (5) the original form of the orifice of the vagina and of the anterior vaginal wall is retained.

Corrosive Sublimate.—Six obstetric and two surgical cases have ended fatally from the use of this substance as an antiseptic during operations. There can be no doubt that the genital tract of a puerperal woman is peculiarly favourable to the absorption of solutions applied to it, as the use of carbolic acid itself has proved. Thone, from his experience at Halle, recommends that sublimate should be used for the disinfection of the external genitals and the hands of those examining or operating on the woman, but not for washing out the vagina or uterus, for which carbolic acid is to be preferred ('Sammlung Klin. Vort.,' 250). This recommendation quite agrees with the view of Mikulicz, of Cracow, who, by the doubts he threw on the disinfecting power of corrosive sublimate, did so much to limit the adoption it was obtaining under the authoritative approval of Koch. Mikulicz holds that, though corrosive sublimate is the most efficient antiseptic for prophylaxis that we know of, it is not adapted to wounded surfaces, on which it is decomposed with the formation of albuminate of mercury, a compound the disinfecting power of which is much less than that of corrosive sublimate itself, or even carbolic acid. Lister's experiments[1] go far to upset this theory; but some support was given to it by the fact, proved by Schiff and Fischer, that corrosive sublimate had less power of disinfecting tubercular sputa than carbolic acid.

Schede has given an account of his experience with corrosive sublimate at Hamburg, where, under peculiarly pernicious hygienic conditions, he had been disappointed with the results of the use of carbolic acid, as compared with those he had seen at Halle and himself obtained at Berlin. He found that its use secured a complete immunity from the more serious infections, and that the healing of the wounds took place with less irritation, was more often and more nearly perfect in its course than he had himself found it to be under

[1] Vide *Lancet*, October 25, 1884.

carbolic gauze. Among the 1,286 operations in which he used it were 25 ovariotomies, all healed without any suppuration.

Schede uses two solutions—one of 1 : 1,000 to the hands, the sponges and drainage tubes, the skin of the patient, external accidental wounds, and with some caution to unhealthy tissues. Small wounds may be treated entirely with this solution, and a single energetic disinfection of even large surfaces—e.g. washing out a large empyæmic cavity—may be undertaken with less fear of intoxication than with a five per cent., or even three per cent., carbolic solution. The weaker solution of 1 : 5,000 alone is used to operative wounds in sound tissues. Schede holds that sublimate will prove more efficacious and certain, more favourable to rapid healing, and more free from dangerous and disturbing effects than any other disinfectant. Its use must, however, be avoided in all cases of wound-infection with high fever, where there may exist affections of the bowels, leading to ulceration or diphtheritic exudation, in which the danger of intoxication is much increased, as well as in all cases of serious anæmia or kidney disease ('Sammlung Klin. Vort.,' No. 251).

At Bonn they have recently had three deaths in sixteen cases of ovariotomy, and as though no symptoms whatever of poisoning were present in any of the three cases, and only in one was there any appearance on section that supported such an idea, the solutions used in the toilet of the peritoneum were much more concentrated—75 : 1000 and 5 : 1000—than recommended by Schede. As a matter of fact, there were found in all these cases signs that the solutions had acted as irritants to those parts of the peritoneum to which they had been applied. Death was in one case due to ileus, and in the other two to paralysis of the heart; and the possibility of the former being strictly due, and the latter reflexively, to the local inflammations has been suggested by Kougenberg and Rippert in their report ('Centralblatt für Gynäkologie,' No. 21).

In No. 34 of the same publication, Dr. Scriba, assistant

to Professor Kaltenbach, in advocating the use of sublimate, alludes to the large quantity of the salt in the solutions used at Bonn, and details the method adopted at Giessen, where Professor Kaltenbach—between October 1884 and July 1885—performed twenty-four peritoneal operations under sublimate disinfection, all of which were followed by recovery. Many of these cases were very complicated—such as intraligamentary ovarian tumour, two intraligamentary myomata of eight and fourteen pounds weight, &c.—and the series contrasted most favourably with the preceding twenty-one laparotomies done under the carbolic disinfection, of which four were fatal—two from sepsis, and two others very probably from sepsis also.

The solution used in the peritoneal toilet, which was made as rapidly as possible, was one of 1 : 5,000—6,000. Several adhesions and the cut end of the pedicle were disinfected with a solution of 1 : 1,000, applied on a sponge on a handle, any excessive moisture being at once taken up by a dry sponge. Continued irrigation of the vagina was never employed, and even in the most protracted cases a minimum of the solution was introduced into the abdominal cavity. (In addition to these two solutions the following were also used:—1 : 10,000, operating room table, apparatus, &c.; 1 : 3,000, operators and assistants to dip their hands in during the operation; 1 : 2,000, to the abdominal wound before the peritoneal cavity is opened and after it is closed, and for washing out the vagina before and after the skin of abdomen, shaven mons veneris, and external genitals have been rubbed with a solution of 1 : 1,000. In this last also the hands are immersed for one minute, after being cleansed with soap and nail-brush, and the ligatures are kept, the silk permanently, the elastic for an hour before use. The instruments, which are as far as possible made each of one piece of metal without wooden handles, are disinfected by dry heat and carbolic acid. All present wear linen disinfected clothes specially provided for laparotomies, and kept between times in closed chambers. The evening before the operation chlorine or

carbolic vapour is evolved in the operating room, in which, next morning, a steam spray is set in action for an hour.)

Convalescence was in every way most satisfactory. No unfavourable symptoms gave us cause for even a temporary anxiety in any case, and the union of the abdominal wound was in nearly every case typically perfect, without even a trace of suppuration in the stitches.

JAMESON JOHN MACAN, M.A., M.R.C.S.

OBSTETRICAL SOCIETY OF LONDON.

THURSDAY, OCTOBER 8, 1885.

Hypertrophy of Lupus of the Female Generative Organs.—Dr. Matthews Duncan read a paper on this subject. He said that hypertrophy was not an essential part of lupus. Extensive ulceration might occur without any hypertrophy. Hypertrophy rarely occurred without some ulceration; ulceration and hypertrophy were to be regarded rather as alternative conditions than as concomitants. The hypertrophies might be minute or might approach those of elephantiasis. The destruction by ulceration in severe cases was greater than the growth by hypertrophy in severe cases. The hypertrophy affected the skin, the mucous membrane, the connective tissue, or the clitoris. The hypertrophy tended to be an outgrowth, not to grow deeply like a cancer. Hypertrophies were generally morbid in form and appearance, but might resemble healthy natural parts. The hypertrophy might affect the thigh and hip. A hypertrophied part might be ulcerated, and the ulceration might heal without the hypertrophy being destroyed. Hypertrophies were generally not sensitive unless inflamed; but some small hypertrophies, especially urethral carbuncles, were often excessively sensitive and painful to touch. Hypertrophies might vary in degree of induration; they were liable to inflammation. Hypertrophied parts might have polypous hypertrophies growing from them, The colour might be red, brown, purple, or white.

Mr. Hutchinson said that he rose in response to the President's invitation, although he had come rather to listen than to speak. He considered Dr. Matthews Duncan's paper a very valuable contribution to the clinical knowledge of a disease in which he had himself taken much interest. The narratives were clear and full, and the coloured drawings which illustrated the cases made them so complete as to give the members of the Society almost the advantage of having seen the patients. He might as well at once avow that a careful perusal of Dr. Duncan's paper (before the meeting), and an examination of the portraits, had led him to form an opinion somewhat different from that which the author had expressed. He felt it to be almost an impertinence to differ from one of Dr. Matthews Duncan's well-known clinical acumen, especially since he alone had actually examined the patients. He felt bound, however, in the interests of clinical accuracy, to question the diagnosis, and he did so with the more freedom because he well knew that there was no one more willing than Dr. Matthews Duncan to court the investigation of his facts. In the first place he felt tolerably confident that all dermatologists would repudiate the name 'lupus' as inapplicable to the disease described; and in the next, he could not help a very strong suspicion that, in all the six patients whose cases had been just narrated, the disease was remotely connected with syphilis. He expressed some surprise that Dr. Duncan had not attempted in any of the cases to show that syphilis was probably absent, and that he had indeed left it for the most part unmentioned. Having stated of the whole set of drawings that, so far as they went, he (Mr. Hutchinson) should have assumed that they were all representations of tertiary syphilis, unless that belief were entirely confuted by the case-narratives, he next proceeded to examine the latter, and he took each case *seriatim*, and showed that Dr. Duncan had recorded facts concerning all the women which were very suspicious. Thus, in one, it was acknowledged that there was a suspicion of syphilis; another had sores, discharge, and a bubo a few years before; and so on; all were married

women, and all were hospital-patients of a class in which syphilis was very common. It must be remembered that the female genitals, when affected in tertiary syphilis, were liable to display some peculiar forms of morbid action. Chronic gonorrhœa very often complicated syphilis in women; and as a consequence of the long-continued irritation of discharges, the clitoris, nymphæ, and labia often became first œdematous and then hypertrophied. These were the conditions which Dr. Duncan's portraits showed. Although they were not all alike, most of them exhibited a combination of elephantoid hypertrophy, with ulceration and the formation of scars. There was, perhaps, nothing that deserved the name of elephantiasis, but there was an approach to it; and, for his part, he (Mr. Hutchinson) believed that the difference was only a matter of degree. In reference to lupus, Mr. Hutchinson stated that he did not believe he had more than once or twice seen true lupus—that was, such lupus as all were familiar with on the face—on the vulva; and he thought it would be a great pity if these cases were placed on permanent record under that name. Not only did their local features differ widely from common lupus, but in not one of them was it recorded that lupus was coincidentally present on other parts of the body. In Dr. Duncan's former paper, he believed that one case had been recorded in which common lupus occurred on the patient's nose, and this was held to be important proof as to the nature of the disease of the vulva. In this instance, however, the narrative mentioned that there was perforation of the palate, a condition known to be infinitely rare in lupus, but very common in syphilis. He should be very much interested in what Dr. Duncan could say as to the exclusion of syphilis in his patients—whether, for instance, he had met with the disease under circumstances in which it was highly improbable that syphilis existed. Such improbability had not been made out, and he thought it had not even been attempted in the paper to which they had listened. As regarded measures of treatment, he was entirely at one with Dr. Duncan, and warmly congratulated him on the

success which had attended excision and free cauterisation of parts. He could not help suspecting that a source of fallacy had existed there as regarded syphilis, and that it had been assumed that diseases which were more successfully treated by local measures than internal specifics were probably not syphilitic. He had, however, if he might be permitted to express a personal opinion, long held that not a few of the tertiary manifestations of syphilis yielded much more readily to local cauterisation than they did to mercury or iodide of potassium. He felt compelled, therefore, to believe, at any rate until further negative evidence was produced, that Dr. Duncan's patients were the subjects of remote syphilitic taint, and that their local disease was partly due to it, and in part to local irritation. If the term 'lupus' was to be used in connection with them at all, it ought certainly, he thought, to be used with the prefix 'syphilitic.'

Dr. Playfair said that he had been in the habit of describing cases like those figured by Dr. Duncan as elephantiasis. He had seen many cases in India, and some of these were very like Dr. Duncan's cases. For his own cases he had used free incision. In his opinion, Dr. Duncan had only given a new, and questionable, name to an old disease.

Dr. Galabin asked as to the histology of the disease, especially in its relation to new growths. In a case of perforation of the body of the uterus by an ulceration, shown by Dr. Duncan some time ago, he had found some tendency to the characters of a new growth in the fact that, in some parts, the cells were joined by tailed processes. He had also regarded lupus of the vulva as a very rare disease. In cases similar to those shown by Dr. Duncan, he had generally found some evidence of syphilis; they did not yield to anti-syphilitic remedies alone, but yielded to excision followed by such remedies.

Dr. Thin had found the microscopical appearances the same in all Dr. Duncan's cases. There was, in all the cases, more or less small-cell infiltration beneath the epithelium, and a number of blood-vessels ran straight to this part.

There was no marked inflammatory changes in the fibrous tissue, which was found in all stages of development. The changes found in lupus vulgaris were absent, but so were also those of syphilitic gumma, as well as of cancer and elephantiasis. The appearances suggested a persistent form of irritation, acting peripherally. M. Vidal, of Paris, informed him that in about 150 cases of women affected with lupus vulgaris the region of the vulva had not been affected once. Professor Kaposi, of Vienna, bore the same witness. He believed that Dr. Duncan's cases formed a separate disease, separate, that was, from syphilis, lupus vulgaris, cancer, and elephantiasis. He did not agree with Mr. Hutchinson, because, apart from the absence of syphilitic history, the appearances themselves differed from syphilis, compared with which the hypertrophy was out of all proportion to the ulceration, and the ulceration was not typically syphilitic in appearance. Still less could he agree with Dr. Playfair as to the cases being elephantiasis, which was well known to be due to obstruction of lymphatic vessels by filaria sanguinis hominis.

Dr. Matthews Duncan had observed this disease for more than twenty years, and had always done his best to exclude syphilis. Mr. Hutchinson relied on the general appearances, the frequency of childbearing, and vaginal discharges as evidences of syphilis. Now, every one at first held the same view; but many syphilologists and dermatologists, and others there and elsewhere—among whom Paget, West, Thin, Kaposi, and Vidal had been mentioned that evening—had satisfied themselves that the disease was not of syphilitic origin. The disease was not new, though little understood. There was a great literature of the subject. He could not himself entertain the notion of the syphilitic origin of a disease occurring in children, in virgins, in all classes of society, confined to the genital organs, and destitute of any evidence of primary, secondary, or tertiary syphilis. The disease had an appearance and history quite distinct from that of tertiary syphilis. He could not allow that outward appearance, childbearing, and vaginal discharges were

evidence of syphilis. Dr. Playfair had said that it was elephantiasis, but it bore no resemblance to that disease in outward characters, nor history, nor histology. Mr. Hutchinson had said that it was not lupus, and yet he held that it was a kind of syphilitic lupus. Dr. Duncan had taken care, in a former paper and elsewhere, to point out that the disease, however much it resembled lupus in some points, was not lupus vulgaris, a disease which neither he nor others more experienced in dermatology had ever seen on the vulva. He called the disease lupus, because it had been called so before, and it was a much easier name than 'esthiomène.' He would soon lay a paper before the Society on the inflammations of this disease, and of its histology. He would only say now that the histology of Huguier, Paget, and Thin lent no support to the theory of syphilis.

WEDNESDAY, NOVEMBER 4, 1885.

On the Suppuration and Discharge of Pelvic Dermoid Cysts.—Dr. Herman read a paper on this subject, of which the following is an abstract. The author first said that while, under ordinary conditions, pelvic dermoid cysts were best treated by laparotomy, yet, when such a cyst had suppurated and burst into one of the pelvic mucous tracts, there would usually be extensive pelvic adhesions, making the operation for the removal of such a cyst more than commonly difficult and dangerous; and, on the other hand, the suppurative process offered some prospect of cure without extirpation. The object of the paper was to assist in the treatment of these cases, by offering as complete an answer as could be given to the following questions: 1. When a pelvic dermoid cyst suppurates and bursts, what may be the course of such a case? 2. What prospect of cure does this event offer? 3. Is this cure complete? 4. How can the cure be best promoted by treatment? It was commonly believed that so long as any part of the lining of a dermoid cyst remained the cavity would not close. He thought there were sufficient cases to show that either this did not always hold good or that suppuration usually

so altered the character of the lining membrane as to make it capable of contracting and closing. The author had had under his own care three cases in which dermoid cysts had suppurated, in two of them bursting into the vagina, in one into the bladder. He had collected from various sources a large number of other cases; and from examination of them he drew the following practical conclusions: 1. The suppuration of a dermoid cyst is sometimes a favourable event leading to its cure. 2. This is especially likely to be the result if the cyst be small and unilocular, and if it have opened into the vagina. 3. An originally very small cyst may, when it suppurates, rapidly attain a very large size. 4. When the cyst is small it may be inverted through the aperture of discharge, become polypoid, and be spontaneously expelled or easily removed by the surgeon. 5. This process may be imitated by the surgeon, but it is not safe unless it can be very easily done. 6. When a suppurated dermoid cyst has been emptied it contracts, and its cavity either becomes obliterated or remains as a small sinus which causes no trouble 7. The first indication in the treatment of a cyst which has burst is to empty it, for cure by suppuration depends upon the cyst being emptied. 8. The opening of the cyst should be enlarged as much as can be safely done, the cavity explored, and its solid contents removed as completely as can be done without violence to the integrity of its wall. 9. If the cyst have discharged into the bladder, its cavity should be reached by vaginal cystotomy, not by dilatation of the urethra. 10. If the cyst be multilocular, or if, after having been emptied as thoroughly as possible, it do not rapidly contract (from which it may be inferred that it has not been completely emptied), it is likely that it will discharge indefinitely, and exhaust the patient's strength; and therefore it should be removed by abdominal section without long delay.

A Case of Obstructed Labour, in which Spontaneous Version followed an Unsuccessful Attempt to Deliver by the Crotchet after Perforation.—This paper was read by Mr. S. D. Hine (Ilminster). The patient had been in labour

thirty hours; liquor amnii escaped twenty-one hours. The cord was prolapsed; the head presented in the first position; the os uteri was dilated; the uterus was in a state of tonic contraction; the conjugate diameter of the brim was under three inches; the head was immovable above it. After ineffectual attempts to deliver with forceps, the skull was perforated, and for about an hour endeavours were made to deliver with the crotchet, but in vain. A consultation was then held, which lasted about ten minutes; and, on examination at the end of this time, the head-presentation was found changed into a breech; a foot was then brought down, and the child thus delivered.

WEDNESDAY, DECEMBER 2, 1885.

Case of Protracted Pregnancy.—Dr. Arnold Thomson (Ampthill) read this case. The patient was a delicate woman, not long married, who had had a miscarriage previously, occasioned by a shock. After this menstruation recurred, and the last period ended June 1884. Her husband left home a week after, and returned on June 16, for one night only, on which coitus took place. He left home the next morning, and was away for four months. Soon after the husband's departure signs of pregnancy appeared. Delivery took place April 13, 1885, 317 days after the end of the last menstruation, or 301 days from the last coitus. The dates were absolutely certain. The child was not weighed or measured; it was a female, and appeared of full average size and weight.

On the Inflammations of Lupus of the Pudendum.—Dr. Matthews Duncan read a paper on this subject; the communication included histological observations and remarks by Dr. Thin. The peculiar inflammations occurring in the course of the disease were described, as well as the strictures which also occurred. These conditions were contrasted with such as occurred in connection with malignant disease. Their treatment was also discussed. The histology of the disease had already been briefly described by Dr. Thin, and will be found in the report of the October meeting of the Society.

A Case of Spurious Labour.—Dr. H. Roxburgh Fuller read notes of a case where this condition was present. The patient, a short, spare woman, aged 31, became pregnant, as she supposed, for the fifth time, in 1882. She had been married over eleven years, had borne four children, and had never miscarried. Her last child was born August 31, 1881, and she suckled it until August 3, 1882. On that day she noticed a pink discharge, 'like a birth-show,' and felt the movements of a child. She at once weaned her child. She had never conceived before while suckling, and she had suffered from morning sickness since April, but did not think herself pregnant till she 'quickened.' From this date the sickness ceased. On cross-examination it was found that the sickness was irregular, and occurred at any time of day; also that the catamenia, absent from the birth of the child till the 'show' in August, returned naturally in September, scantily ten days later, and at irregular intervals in October and November. In December, ordinary morning sickness began, and persisted till 'labour' began. In December, the catamenia were absent. On January 1, 1883, 'labour' began, with 'niggling' pains in the stomach and thighs, which continued during the 2nd and 3rd; but on the 4th true labour came on, the pains becoming strong, frequent, and forcing; the 'waters' soon broke, and she sent to St. George's Hospital for assistance. Nine hours later, the student in attendance sent for Dr. Fuller, as resident obstetric officer, reporting that the labour was making no progress, and that the patient was becoming exhausted. The patient remarked to Dr. Fuller that she thought it was a cross-birth, as she missed the pressure of the child's head. The author found all signs of advanced pregnancy absent. The pains occurred every three or four minutes, and the bearing down forced the small cervix uteri nearly to the vaginal outlet; while at the same time urine escaped. The pains were typical of the second stage of labour. Dr. Champneys was called to the case, and diagnosed pregnancy of six weeks, which proved to be correct. He also succeeded in convincing her that she was not in labour, her

belief in this having been unshaken till then. Dr. Fuller remarked on the belief in pregnancy which persisted in the absence of all signs and of all symptoms except 'fœtal movements'—on the occurrence of true conception during the progress of the case, which was not disturbed by the 'labour.' He also alluded to the two classes of spurious pregnancy—(1) in which all symptoms except fœtal movements were absent, and (2) the class in which the mammary and other sympathetic signs were more or less marked. The latter class, as Harvey pointed out, are noticed in animals.

OBSTETRICAL SOCIETY OF EDINBURGH.

WEDNESDAY, MAY 27, 1885.

Case of Alexander-Adams' Operation.—Dr. Alexander Sinclair read a paper on this subject. The patient, E. F., aged 46, married when 29. Has had two children and one miscarriage. Menopause occurred at 44. Her first confinement was tedious, necessitating the use of instruments. Shortly after rising she noticed that her womb came down on the slightest exertion. She had always suffered much inconvenience from constipation, and had considerable pain when the womb protruded beyond the vulva. On examination the cervix uteri was found to have undergone atrophy, and the os uteri was small, roughened, and bled when touched. There was much leucorrhœa.

Dr. Sinclair draws attention to the point, that the external abdominal ring cannot always be felt through the skin, but after making the incision no difficulty is experienced in ascertaining its exact position. The ligaments were drawn out to the extent of an inch and a half. Two strong silver wire sutures were applied at upper edge of wounds on both sides. They included the skin, fascia, pillars of ring, and ligaments. These sutures were fastened by twisting, and the ends left somewhat long. The rest of the wounds were closed with silk-gut. A ring pessary was introduced, and the surfaces of the wounds

covered with protective and gauze. Considerable tension at site of wound existed for four days, the abdominal wall being deeply drawn in at these points. The sutures were removed on the seventh day, and the wounds were healed by the sixteenth, and the patient allowed to rise from bed. Thirty-four days after the operation the pessary was removed. Three months subsequently she was able to do her ordinary duties, and there was no return of prolapse.

Remarks.—Of the benefit derived from the operation there can be no doubt in this case. The steps of the operation presented no peculiar difficulty, and it was a bloodless one. One can hardly believe that such a simple operation was not thought of at an earlier date. It seems to me that the probable cause may have partly arisen from the term 'ligament' being applied to these uterine appendages. Now, anatomically, we know that the structure of the ligament consists chiefly of muscle fibres identical with those of the uterus, mingled with many of the striated variety, and that these cells undergo hypertrophy and multiplication during pregnancy in the same manner as those of the uterus. These ligaments, or rather muscles, are attached by three origins to, (1) the tendons of internal oblique and transversalis, near symphysis pubis, (2) to outer pillar of ring, and (3) to inner pillar of ring. They pass backwards and outwards, becoming fleshy in front of epigastric artery, and behind the lower border of internal oblique and transversalis. They get between the layers of the broad ligament of the uterus, and finally are inserted into the anterior and superior part of that organ. In the dog, sheep, and cow these ligaments pass upwards and forwards, and are attached to the aponeurosis of last rib. M. Velpeau, Maygrier, and, later still, Mr. Rainey, who has written a minute description of their structure, believed that these ligaments contract during sexual intercourse, and by elongating and narrowing the upper part of the vagina, tend to facilitate the entrance of semen into the uterus. I cannot myself understand how the drawing away of the os uteri and elongation of the vagina can facilitate the entrance of the

seminal fluid. I should rather imagine the opposite to be the result. That these cords contract during labour I have frequently verified. They can be felt most readily during the third stage of labour, as hard, thick cords, drawing the fundus uteri towards the pubes, and probably checking the tendency to prolapse of the uterus by maintaining it in the axis of the brim of pelvis. I cannot help thinking it is by replacing and maintaining the uterus in the normal position of slight anteversion that this operation for prolapse acts beneficially.

There was one other point that struck me forcibly during the treatment, and that was the little or no apparent benefit derived from the use of the pessary. The tension to the abdominal walls was not relieved. I believe the stretching of the upper part of the vagina in its transverse diameter may even have increased the traction on the cords. I shall certainly in any future operation endeavour to do without a pessary, or use one which will not cause distension of the vaginal walls, but will directly support the uterus, and at the same time assist the action of the ligaments by stretching the vagina in its longitudinal diameter.

WEDNESDAY, JULY 8, 1885.

Case of Post-partum Inversion of the Uterus.—Dr. Peter Young read notes of this case for Dr. G. Michael. On Saturday, March 14, about 10.30 A.M., I was asked to go and see a patient who, the messenger said, had had a child some time before and was supposed to be 'going out of her mind.'

On my arriving there—the distance was not more than 100 yards—it was at once evident that the woman was suffering from loss of blood. She was throwing her arms about and sighing deeply. Her face was deadly pale, and her skin was covered with a cold, clammy perspiration. The pulse at the wrist was scarcely perceptible, and she was almost unconscious. On inquiry I was told that the child was born at a quarter to nine, and that the placenta had come

away half an hour afterwards all right. The labour was not tedious, and the woman was delivered in bed. On placing my hand over the abdomen I could not feel the uterus. On proceeding to make a vaginal examination, the bed was found soaking in blood and covered with a large quantity of clots. On introducing the hand into the vagina, I found a large globular mass lying just within, and bleeding profusely. Bimanually the cup-shaped depression could be felt by pressing deeply. Repeated attempts failed to reduce the inversion, and the woman died shortly afterwards with all the signs of death from hæmorrhage. The post-mortem on the following day confirmed the diagnosis.

The Pathology of the Post-partum Uterus: (1) Septicæmia; (2) Adhesive Membranes.—Dr. A. H. Freeland Barbour read a paper on this subject. He had examined the pelvic contents and other organs of a woman in whom well-marked symptoms of septicæmia had appeared on the eighth or ninth day of the puerperium, and proved fatal on the twelfth. With regard to the naked-eye appearance of the pelvic organs, the most noteworthy feature was the absence of any indication of peritonitis, either general or local. There was no marked affection of the cellular tissue. The broad ligaments were not thickened by inflammatory deposit. The cellular tissue round the cervix was soft and œdematous, but showed no evidence of suppuration. Under the microscope micrococci were found in the uterus, kidney, and heart. The micro-organisms were seen aggregated together, and plugging the lumen of the blood-vessels. They were pretty numerous in the blood-vessels of the placental site, and also in the uterine wall. They filled the lumina of the smaller vessels, and in the larger appeared as patches in the centre of blood-clots or of granular *débris*. In some sections, where the micrococci were isolated, one could see them disposed in chains of from three or four members and upwards; these chains had a sigmoid or tortuous disposition like dry vermicelli. The sections of the cellular tissue and broad ligament showed nothing worthy of note. They were made to see if

the micrococci could be traced through the lymphatics, but this could not be done.

As to the relation existing between these micrococci and the disease, Dr. Barbour says: Against the possibility that they were developed after death are the facts that they are found in various organs of the body, and that when found they are present only in the blood-vessels, and just as we should expect to find them (most frequently in the smaller vessels, and sometimes just beyond the bifurcation of a vessel) if they were carried by the circulation. Unfortunately, the blood was not examined during life. As to their origin, in the absence of endocarditis and of any evident source of septic material in the other organs of the body, we can refer it only to the septic changes in the uterus.

As to how they passed into the circulation we note that in the case of the uterus there are three modes of septic infection: (1) absorption by the lymphatic system—this is by far the commonest, as we see every day in cellulitis or parametritis after labour; (2) extension of septic changes along the mucous membrane of the Fallopian tubes into the abdominal cavity—of this the typical instance is gonorrhœal inflammation; and (3) direct passage of the septic matter into the circulation—direct because in both (1) and (2) the septic matter may ultimately pass into the circulation and cause metastatic abscesses. The puerperal uterus presents conditions which are peculiarly favourable for this. The veins close by thrombosis; and should these large thrombi become septic, we may have an enormous quantity of toxic material rapidly thrown into the circulation. The last mode of infection seems to be the most probable one in this case. The absence of marked inflammatory changes in the cellular tissue, the peritoneum, and Fallopian tubes is against the occurrence of (1) and (2).

The practical conclusion Dr. Barbour draws is that the condition of the interior of the uterus should occupy the same place in the mind of the obstetrician that the stump does in the mind of the surgeon. The condition of the lochia gives

valuable information as to the state of the uterine wound. We must remember, however, that we may have septic absorption going on without fœtor of the lochia. We must distinguish between putrefying matter (which will, of course, produce fœtor) and septic matter. All putrefaction within the uterus after delivery will cause septic poisoning, but not all septic poisoning implies putrefaction. We have a pathological basis for this distinction in the difference between the microbes characteristic of putrefaction and those described in septicæmia. Dr. Barbour points to the advantages of corrosive sublimate as an antiseptic.

Fourteen Cases of Ovariotomy. By ARTHUR V. MACAN, M.B., Master of the Rotunda Hospital.

OF these cases only one, an intra-ligamentary cyst, was fatal, dying from shock sixty hours after the operation. Four cases were multilocular, one a bilateral dermoid cyst. In the latter the abdomen was reopened, and a drainage tube inserted the day after the operation, as the patient appeared to be dying from septicæmia; she made a perfect recovery. In a second case a drainage tube was inserted thirty-four hours after the operation, there having been bleeding from the pedicle; this also did well. In one case an elastic tumour had been found filling up the left side of the pelvis, elevating the fundus uteri above the right Poupart's ligament. On pressure being made this rose with a jerk into the abdomen, and the uterus fell down into its place. An ovarian tumour was diagnosed, and as twisting of the pedicle was suspected, the case was operated on, and the diagnosis justified.

Dr. Macan advocates antiseptics, a large incision with a free opening of the cyst with the scalpel when necessary, and especially recommends all intestinal and omental adhesions being brought into sight in the abdominal wound when being separated.

Successful Laparotomy after Traumatic Rupture of the Uterus.—On July 7, 1884, Dr. Plenio operated in the

hospital at Elbing on a woman who, falling backwards from the top of a high load of hay on to her shoulders, had been brought into the hospital at Elbing, her uterus being ruptured and the child lying free in the abdomen. The placenta was still in the uterus, but detached, and there was no difficulty in removing it and the fœtus without any escape of blood or liquor amnii into the abdominal cavity. The rupture was entirely on the anterior surface, involved the fundus, and passed nearly in the middle line to the level of the inner os, and then almost at right angles to the left, separating the corpus uteri from the cervix for nearly 2.5 cm. The edges, smooth and but slightly everted, were united by knotted silk ligatures passing through the entire muscular substance. After the uterine cavity had been thoroughly disinfected, a drainage tube was passed into the vagina from the inner edge of the rupture near the fundus, the abdominal wound sewn up, and dressed with iodoform gauze.

There was considerable constitutional disturbance, fever, and troublesome though not extreme tympanitis; tenderness in both parametria, a well-marked exudation resulting on the right side. Voluntary micturition was not established till after nine days, but the patient, in spite of her high temperature, felt well. The treatment consisted in opiates with suitable diet, frequent subcutaneous injection of ergot, and washing out of the genital track with three per cent. carbolic acid solution. The sutures were removed on the seventh day, but after large fœtal masses had been brought away by a copious clyster on the eighth day, the abdominal wound gaped and was again stitched up. Subsequently a circumscribed abscess formed between the uterine and abdominal peritoneum, was incised through the cicatrix, and, as it communicated with the uterine cavity, a large drainage tube was passed through the incision into the vagina, securing a free exit for the discharge, and permitting disinfection of the abscess and genital track. This tube was afterwards removed, and the fistula, though still existing, promised an early and permanent cure when the patient was discharged on October

10, when also the exudation in the parametrium had been absorbed. ('Centralblatt für Gynäkologie,' Nov. 21, 1885.)

Alexander's operation was performed at Erfurt by Dr. Zeiss, on August 19, 1885, in a case of retroflexion and enlargement of the womb, with descent of all the pelvic organs and prolapse of the left ovary. The patient was a pluripara, who had suffered more or less for more than five years, becoming much worse since her last confinement, eighteen months before the operation. Menstruation occurred every three weeks—short, but painful and profuse, and there was great leucorrhœa, pain, and bearing down. No treatment gave relief, though everything was tried, including the operative union of a bilateral cervical fissure; no pessary kept the uterus in position—indeed, none could after a time be worn because of the prolapse of the left ovary. The patient could not walk a step, or even sit up for any considerable time, without the most violent pain.

The uterus was anteverted bimanually after Dr. Zeiss had found and prepared the round ligaments; the latter were then drawn out about 6 to 8 cm., tied together over a plug of gauze, and sewn with catgut, each to the inner pillar of its ring and to the integuments; drainage tubes were placed in the wounds, which were united by silk ligatures and dressed antiseptically, a ring pessary being placed in the vagina.

There was no reaction. The tubes were removed on the fifth, the sutures on the seventh day. The mummified ends of the ligaments were detached on the tenth and twelfth days, and at the date of the report, six weeks after the operation, the uterus was in the normal position, and the patient, who left her bed on the thirtieth day, was able to sit up and occupy herself nearly all day afterwards with light work, was completely free from pain, and could eat and sleep well, the pessary causing her no inconvenience whatever. ('Centralblatt für Gynäkologie,' October 31, 1885.)

JAMESON J. MACAN, M.A.

CHICAGO GYNÆCOLOGICAL SOCIETY.

FRIDAY, NOVEMBER 27, 1885.

Remarks on the Toxic Properties of Sassafras.—Dr. John Bartlett read a paper on this subject. Sassafras was discovered in Florida by the Spaniards, and named by the French in 1562. It was used by them in association with other native herbs as a remedy for malarial diseases. Though occasionally prescribed in combination in rheumatism and syphilis, and regarded as possessing diuretic, diaphoretic, and tonic properties, it has fallen into disuse. So that by referring to such books as were within my reach—namely, Motherby (1785), Parr (1809), Eberle, Trousseau, Mitchell, Waring, Stillé, Ringer, Bartholow, Phillips, Wood, Fluckeger, Farquharson, Brunton, Wormly, and Blyth, and the U. S. Dispensatory, National Dispensatory, Christison's and King's Dispensatories —I can find no mention of the possession by sassafras of any decided therapeutical or noxious power.

More than twenty years ago Dr. Thompson, of Tennessee, stated that sassafras was an antidote to henbane and tobacco; and later, in 1870, Dr. Lyle, of Indiana, declared that he had used the oil of sassafras in a case of stramonium poisoning with the happiest results. Dr. Lyle affirmed that sassafras had power to destroy all insect life, and was an effectual antidote to the venom of the copperhead snake. In 1883 we find that Dr. Hinton claimed that sassafras tea was almost a specific for the rash produced by poison oak.

Recently paragraphs have appeared in the medical journals, in which it is stated that sassafras is not the innocent agent that it has been supposed to be, but that in reality it has violent toxic properties. This statement is made upon the authority of Dr. Charles L. Hill, from whose paper, read before the 86th session of the Medical and Chirurgical Faculty of the State of Maryland, in April 1884, the following report is extracted :—

'A case of poisoning by the oil of sassafras, that once came within my knowledge, proved that it possesses far more active properties than is generally supposed, and I have been able to demonstrate by experiment on the lower animals that, instead of being a harmless, inert drug, it is a strong nervous sedative, anodyne, and soporific, and in over-doses a dangerous narcotic poison. A policeman, attracted by the sound of a falling window and other suspicious noises proceeding from a gentleman's office, entered the room to ascertain the cause. He found no one present but a boy, who was lying unconscious on the floor. He took him at once to the station-house, where I saw him shortly afterwards. The officers had already diagnosed his case as one of opium-poisoning, and were vigorously striving to keep him awake by walking, flogging, and such other means as are usually resorted to in these emergencies. His stupor was profound, and he no longer made an attempt to walk, but was literally dragged about in their efforts to revive him. He spoke occasionally, but only to beg them to allow him to sleep. He was in a condition of great relaxation; skin covered with a profuse perspiration; countenance pallid; pulse rapid, but weak and thready. His pupils were *normal*, and there was a strong odour of sassafras in his breath. As quickly as possible an emetic was administered, which produced a copious emesis, redolent with the odour of sassafras, with drops of the undissolved oil floating in the liquid. This was followed by free draughts of warm water, until a faint odour of sassafras was discoverable. The vomiting relieved him, and he was soon restored to consciousness. He felt no discomfort except a sense of weakness and exhaustion, and was soon able to give the following account of himself: His employer having gone home, he was preparing to close up the office, when he espied a bottle of the oil of sassafras which had been left on the desk. Remembering that sassafras had been recommended for the removal of an eruption that disfigured his face, he thought this a good opportunity for giving it a trial, and turning up the bottle—to use his own language—he took

two large swallows of its contents. In a few minutes he began to feel very *stiff*, as he expressed it, but proceeded to close up the shutters preparatory to leaving for home. He raised the window for this purpose, but had not strength to hold it in this position, and it dropped from his grasp, and at the same time he fell to the floor unconscious. This suggestive case led me to make numerous experiments on the lower animals, with very interesting results. Ten drops of the oil were injected hypodermically under the skin of a mouse. The animal quickly succumbed, and died convulsed. By repeated experiments I was able so to regulate the dose as to get the characteristic effects of the drug without causing the speedy death of the mouse. A glass rod was dipped into the oil and held in front of the mouse, and he seized it with his mouth. This was repeated at intervals of a few minutes, until a sufficient quantity was taken to produce the desired effect. The first symptoms observed when a small quantity was thus taken was a slight convulsive movement, which was repeated at intervals of a few seconds, and agitated the animal's body very much like a severe hiccough. This gradually increased in severity, the movements became more unsteady, the body more arched, and the limbs so stiff that the mouse stood on tiptoe. It was noted that the one idea of escaping from the trap still predominated over all else, as he continued to climb up on the bars of the cage, only to fall on his side or back at each convulsion, until no longer able to rise.

'I have repeated these experiments many times with great uniformity of result. Sometimes they would dance about for half an hour, with a peculiar convulsive movement that would jerk the head and front feet from the table. Again they would fall on their side with each convulsion and regain their feet immediately only to repeat the same movement. With cats and dogs the result was somewhat different. A drachm under the skin of a cat caused such profound insensibility that she was supposed to be dead, and thrown away, but it seems that only one of the reputed nine lives of the animal

had been reached, as the next day she turned up none the worse for the experiment. A full-grown dog was paralysed in his hind legs by a similar dose hypodermically over the loins, but it recovered. Many other experiments might be adduced, but I will not trespass on your time. There is one other property possessed by this drug that is worthy of mention—it is a germicide and anti-ferment of no mean quality. In some clumsy experiments made by myself I have estimated its potency in this field as about one-half the strength of carbolic acid. It has long been used as a domestic remedy for the destruction of lice and other vermin.'

For some years past I have had an intention of bringing before the profession reasons—rather feeble, it must be admitted—for the supposition that the medicine under consideration has marked potency in a direction, so far as I know, not suspected by medical men. Up to this time the declaration on the part of standard writers that sassafras is a remedy of questionable power, and the fact that it is hawked about the streets and used freely as a tea all over the country, have caused me to refrain from bringing before a scientific body my limited experience presently to be detailed. But the recent declaration that this drug possesses toxic properties may justify me in making the following statement.

Years ago I was called to a woman among the poorer classes, of good intelligence and education, who was having a miscarriage. Upon my inquiring as to the cause of the mishap, with a prefatory reference to her poverty and already large family, she stated that she had induced the abortion herself—that she had done so on previous occasions. She had employed, she said, 'what other women used,' sassafras tea. She was surprised that I did not know of the property of sassafras as an oxytoxic. She spoke as if all her friends knew how to use it as an ecbolic, and she evidently looked upon it as a specific. Tea, she said, made from four or five pieces of the root, as large as the thumb and twice as long, would produce abortive effect.

A year or two later I was called to a woman two months pregnant. For several days she had had symptoms of miscarriage of so pronounced a character that arrest of the process was doubtful. I found the patient very anxious to have a child; she disclaimed the intention of inducing abortion, and to all my inquiries as to a possible cause of the hæmorrhage she gave answers which left me no further question except this: 'Have you been drinking sassafras tea?' Surprised, she replied that for a week past she had used it at breakfast and supper. The proper remedies for her condition were prescribed, the possibly offending tea left off, and in twenty-four hours all was quiet *in utero*.

Further than this my experience with sassafras as a possible abortifacient does not extend; possibly some one present can supplement my remarks with knowledge or experience of his own.

A study of the toxic effects of sassafras as reported by Dr. Hill, and here suggested, would seem to show a triple resemblance to three familiar articles—opium, strychnine, and ergot.

In its action as a narcotic and sudorific it resembles opium.

In its property of inducing tetanic and clonic spasms, followed by paralysis, it is similar to strychnine.

In its power hinted at of exciting the uterus, it may be likened to ergot.

It may be of interest here to call attention to the fact that the first reference to the use of ergot as an ecbolic was made by Stearns in 1807, whereas it had been used by midwives certainly as early as 1688, and probably very much earlier.

Dr. James H. Etheridge referred to the action of the oil of sassafras on the motor centres in the spinal cord, supplying the uterus.

Dr. Edward Warren Sawyer said in New England sassafras was a popular emmenagogue. Mothers were in the habit of giving decoctions of sassafras and tansy to their daughters in case of delayed or suppressed menstruation. Many of the essential oils produced the effects ascribed to

sassafras by Dr. Bartlett. In the South, oil of sassafras was a popular remedy for uterine disease.

The President inquired as to the chemical constitution of the volatile oils.

Dr. H. P. Merriman replied that many of the volatile oils were identical in chemical relations, but differed in physical properties. Such oils were *isomerides*. The essential oil of lemons, of bergamot, neroli, lavender, pepper, camomile, caraway, clover, &c., are isomerides of the oil of turpentine. Oil of sassafras was an isomeride; whether or no of the turpentine group, he could not say. Oil of turpentine was a hydrocarbon, possessing the formula $C_{10} H_{16}$.

Dr. H. T. Byford was of the opinion that the oil of sassafras exerted its influence locally upon the alimentary canal and pelvic viscera, through which it was excreted, rather than upon the uterine nervous centres, as in the case of ergot. This would account for its popularity as an emmenagogue, mentioned by Dr. Sawyer. He had recently given one drop, combined with one-half grain of piperin, every three hours, for two weeks, in case of typhoid diarrhœa. Slight strangury, disappearing with the discontinuance of the drugs, was produced.

Remarks upon a Teratome.—Dr. Charles Warrington Earle presented for Dr. Joseph Haven a teratome, corresponding in development to the third month, and bearing an asserted resemblance to a pup. The following history was read :—

Dr. Haven had attended the family of Mrs. H. for the past four years. During this time he had had occasion to notice that the younger daughter was a person unusually strong in her likes and dislikes, of a nervous temperament, slight build, yet a sensible, educated, and attractive girl. On September 8, 1885, this young lady, in company with her sister, called at his office to consult him with reference to her condition. He made the following entry in his case-book, as the result of her visit :—

'Mrs. D., nineteen years old, married one and one-half

years, always regular as to her courses up to July 21, since then no show. Physical signs point to pregnancy in the sixth week.'

A few days later he saw her again. She was nervous and highly excited—almost hysterical. She told him in an excited manner that a dog had jumped on her, and that she 'hated dogs.' She complained of pain in the abdomen, low down.

From that day until November 1 Dr. Haven saw her several times. Each time she was threatened with miscarriage, and each time she declared she was positive she could never carry that child. Her husband and sister told him that, asleep or awake, her mind seemed to dwell continually upon that dog; that she daily wondered if the child would be marked. Mr. D. said that ever since he has known her she has been afraid of dogs; she would always cross the street rather than meet one, and he has often jokingly refused to take her out with him, telling her, as an excuse, that they might see a dog, and she would make a scene.

On the night of November 1 the husband roused Dr. Haven, desiring him to go over and see his wife, thinking it to be only a repetition of former attacks. An examination proved that Mrs. D. was about to lose the contents of the uterus. She was flowing constantly. The os had dilated slightly, and Dr. Haven could just reach the presenting part. The history of the miscarriage was the usual one, and the result is seen in the specimen presented. She insisted on seeing the fœtus, and declared it to be the image of the dog that had frightened her.

A general discussion upon the subject of maternal impressions followed.

Artificial Abortion. — Dr. Charles Warrington Earle presented specimens from a case of artificial abortion. The fœtus corresponded in development to the fourth month of pregnancy, and was not decomposed. It was closely enveloped in the membranes, and entire absence of the liquor amnii was

noticed. Hæmorrhage into the placenta and decidua was not observed. The following history of the case was read:—

Mrs. F., American, has given birth to five children, the youngest twenty months old; labours always normal; has a history of anæmia for some months', if not years', standing; last menstruation ended May 20, 1885; in June had a very slight discharge of blood; during the weeks following she would occasionally lose a small amount of blood, at other times there would be profuse hæmorrhage lasting twenty-four hours. She had at one time a white, sticky discharge, something like the albumen of an egg. October 1, began to flow constantly, with some pain in back and sides, particularly the left. Was seen by Dr. St. John, October 12, at which time he administered the usual styptics with rest. She continued to flow, with pain, for another week, when hæmorrhage was so severe and prostration so pronounced, and with the suspicion of *placenta prævia*, it was decided that temporising means should cease. After consulting with Dr. Earle, it was decided to induce labour. A catheter was introduced and allowed to remain twenty-four hours, when pains came on and patient was delivered October 17, 1885. During the entire period of gestation the woman could not detect the usual signs of her former pregnancies. She made a good recovery, and menstruated November 20. There had been no discharge of water perceptible to the lady during the entire period of pregnancy.

DISCUSSION.

Dr. W. W. Jaggard thought Dr. Earle's case was a typical example of the condition technically termed *mummification.* The fœtus dies, and the fluid constituents of its body and envelopes are gradually resorbed. Mummification is usually observed in connection with twin pregnancies. One child is usually perfectly developed, while the other is converted into a mummy-like object.

Maceration and ***mummification*** of the fœtus are observed when the membranes are intact; ***putrefaction***, after rupture and entrance of air into the uterine cavity. Dr. Earle's case was probably not an example of that rare condition, abnormally small amount of amniotic fluid. There were no abnormal amniotic foldings, nor the fœto-amniotic bands descibed by Simonart.

W. W. JAGGARD, M.D., *Editor.*

CORRESPONDENCE.

ALEXANDER'S OPERATION.

To the Editor of the British Gynæcological Journal.

DEAR DOCTOR,—Part III., November 1885, of your esteemed periodical reached me to-day. Permit me to say a few words in reply to Dr. Alexander's strictures on my experience in the performance of his ingenious and valuable operation of shortening the round ligaments for retroversion, &c.

Dr. Alexander pays me the high compliment of thinking my objections to his operation, in many cases, worthy of frequent reference and refutation. But he errs when he speaks of 'tiros in surgery,' and in assuming that 'the conclusions of Dr. Mundé, if correct, would almost destroy the value of the operation.'

In the first place, an army surgeon during three wars (medical cadet, U.S.A., 1864; volunteer assistant-surgeon in the Austro-Prussian war, 1866; and battalion surgeon in the field, Bavarian army, 1870-71) is no 'tiro in surgery,' although I admit that my experience in the particular region of the body involved in Alexander's operation is limited.

In the second place, I contend that if only one out of ten (merely to give an estimate) of the otherwise incurable cases calling for that operation can be permanently relieved thereby, it is a great boon to suffering woman, for which we have every reason to thank Dr. Alexander and those who with and after him have perfected this operation.

No doubt the experience of a surgeon skilled in herniotomy must render the detection of the terminal filaments of the round ligaments far easier than it is to one who, like myself, seldom has occasion to do anything but laparotomies, and operations in the cervix, vagina, and perineum. But I have now done six Alexander's operations (two within two months), have found the ligaments in three, and missed them in the same number of cases; and I believe that I know whereof I write when I reaffirm what I said in the report Dr. Alexander

objects to, viz. that the doubt of finding the ligaments must always give to the operation an element of uncertainty.

In my first additional case (No. 5) I had a spare, slender subject, who had undergone six operations at other hands for complete laceration of the perineum, which left her vagina so short and her uterus so low that no vaginal supporter could be retained. I cut down for the round ligaments, an assistant guiding me step by step by reading from Dr. Alexander's recent description of the operation in the 'Medical Press and Circular' (I believe), written in reply to my report of my first four cases. I found the ring, but not the ligament, until I searched in the flaps drawn away by the retractors, when I easily recognised the ligament and drew it out. On the left side it was in the outside flap; on the right side, in the inside flap. The remaining steps of the operation were easy, and a complete success was achieved. The former physician of the patient writes me, under date November 27, 1885, as follows:—

'Dear Doctor,—I wish that you would make a few notes of Mrs. C.'s case (the lady whom I sent you, and on whom you performed Alexander's operation). She called to see me to-day, and I consider your success in her instance as something almost unprecedented. She has just passed through a period free from pain, and declares herself a new woman. I congratulate you.—Sincerely, H. C. Coe.'

In my next case (No. 6), two weeks ago, nearly two inches of adipose tissue was found over the ring, which I easily and thoroughly exposed. But no trace of anything resembling the ligaments could be found. Dr. Ely Van de Warker, of Syracuse, N.Y., a well-known and experienced gynæcologist, was present and assisted me, but likewise failed to see anything in the mass of fat and fascia that could be taken for the round ligaments. I therefore narrowed the vagina and perineum, and the patient is doing well. Now, why can I find the ligaments in one case and fail in another? Simply because, as I take it, spare women are favourable subjects and fat women are not.

I shall persevere *on suitable subjects*, and hope to be able to avail myself of Dr. Alexander's instruction and courtesy in demonstrating to me his operation next summer.

Certainly no one would be less willing to detract from Dr. Alexander's merit in devising this most ingenious and valuable operation than I; only I felt it my duty to limit its range in accordance with my own small experience.

Yours truly,

PAUL F. MUNDÉ.

20 West 45th Street:
November 30, 1885.

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FOUNDED 1884. INCORPORATED 1885.

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